2nd Annual NIH Conference on the

Science of Dissemination and Implementation: Building Research Capacity to Bridge the Gap From Science to Service

January 28-29, 2009

Natcher Conference Center
NIH Campus | Bethesda, Maryland

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA
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OFFICE OF BEHAVIORAL AND SOCIAL SCIENCES RESEARCH

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Acknowledgement

The 2nd Annual NIH Conference on the Science of Dissemination and Implementation: Building Research Capacity to Bridge the Gap From Science to Service is supported primarily by the NIH Office of Behavioral and Social Sciences Research and in part by the following:

John E. Fogarty International Center for Advanced Study in Health Sciences
National Cancer Institute
National Center for Research Resources
National Institute on Drug Abuse
National Heart, Lung, and Blood Institute
National Institute of Mental Health

We would also like to thank the FOUNDATION FOR THE National Institutes of Health PARTNERS FOR INNOVATION, DISCOVERY, LIFE with generous support from the William T. Grant Foundation for sponsoring the poster reception.

Foreword

On behalf of the Office of Behavioral and Social Sciences Research and the NIH Conference Planning Committee, it is my pleasure to welcome you to the **2nd Annual NIH Conference on Building the Science of Dissemination and Implementation**. The tremendous turnout for this conference is encouraging evidence of a growing scientific interest in dissemination and implementation research. This year's theme, **Building Research Capacity to Bridge the Gap from Science to Service**, is intended to address the limited capacity within the research and practice communities to conduct the necessary studies to maximize the public health impact of advances in health and medicine. We hope that you will find the format, including Plenary Sessions, Think Tanks, Oral and Poster Presentations helpful in stimulating an exchange of ideas for enhancing research capacity.

For the purposes of this conference, we use the following definitions as put forward in the trans-NIH Program Announcement **Dissemination and Implementation Research in Health**, http://grants.nih.gov/grants/guide/pa-files/PAR-07-086.html.

Dissemination is the targeted distribution of information and intervention materials to a specific public health or clinical practice audience. The intent is to spread knowledge and the associated evidence-based interventions. Research on dissemination addresses how information about health promotion and care interventions are created, packaged, transmitted, and interpreted among a variety of important stakeholder groups.

Implementation is the use of strategies to adopt and integrate evidence-based health interventions and change practice patterns within specific settings. Research on implementation addressed the level to which health interventions can fit within real-world public health and clinical service systems.

This distinction needs to be made because interventions developed in the context of efficacy and effectiveness trials are rarely transferable without adaptations to specific settings. Therefore, research is needed to examine the process of transferring interventions into local settings, settings that may be similar to but also somewhat different from the ones in which the intervention was developed and tested.

More present than ever within the research community is the belief that to optimize public health we must not only understand how to create the best interventions, but how to best ensure that they are effectively delivered within clinical and community practice. This is the focus of dissemination and implementation research, and building this knowledge base is imperative to get the best return on decades of investment in biomedical, behavioral and social sciences research.

Again, welcome and thank you for your participation.

Sincerely,

Chair, Conference Planning Committee
Helen I. Meissner, Sc.M., Ph.D.
Office of Behavioral and Social Sciences Research
Office of the Director, NIH

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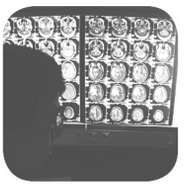
Agenda






Agenda

Day 1: January 28, 2009

8:00-8:30am	**Registration**
8:30-8:45am	**Welcome** Helen I. Meissner, ScM, PhD Office of Behavioral and Social Sciences Research, NIH **Opening Remarks** Christine A. Bachrach, PhD Acting Director, Office of Behavioral and Social Sciences Research, NIH
8:45-9:30am	**Plenary Speaker** Jim Yong Kim, MD, PhD Professor and Chair, Department of Social Medicine, Harvard Medical School Director, François-Xavier Bagnoud Center for Health and Human Rights Harvard School of Public Health
9:45-11:15am	**Concurrent Session I (see page 31 for list)** (Think Tanks, Panels & Oral Presentations)
11:15-11:30am	**Break**
11:30am-1:00pm	**Concurrent Session II (see page 33 for list)** (Think Tanks, Panels & Oral Presentations)
1:00-2:00pm	**Lunch** (on your own)
2:00-3:30pm	**Concurrent Session III (see page 35 for list)** (Think Tanks, Panels & Oral Presentations)
3:30-3:45pm	**Break**

3:45-5:15pm **Dissemination and Implementation Infrastructure: Perspectives from CTSA, CDC, HRSA, NICHD, HMORN (Main Auditorium)**

Moderator: Donna Jo McCloskey, PhD, RN
National Center for Research Resources

Panelists: J. Lloyd Michener, MD
Clinical and Translational Science Awards (CTSA)

Mark C. Hornbrook, PhD
HMO Research Network

Ahmed Calvo, MD, MPH
Health Resources and Services Administration (HRSA)

Eduardo Simoes, MD, MSc, MPH
Centers for Disease Control and Prevention (CDC)

Linda Wright, MD
The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)

5:15-6:30pm **Poster Session/Reception (Atrium)**

Day 2: January 29, 2009

9:00-9:30am **Overview of NIH Dissemination and Implementation Research Opportunities**

Presider: David Chambers, DPhil
Associate Director, Dissemination and Implementation Research
National Institute of Mental Health

NIH Program Contacts: Redonna K. Chandler, PhD
National Institute on Drug Abuse

Lawrence J. Fine, MD, DrPH
National Heart, Lung, and Blood Institute

Karen Huss, PhD, RN, APRN-BC, FAAN, FAAAI
National Institute of Nursing Research

Linda Kupfer, PhD
John E. Fogarty International Center

Cynthia A. Vinson, MPA
National Cancer Institute

Linda Wright, MD
The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)

9:30-11:00am	**Concurrent Session IV (see page 37 for list)** (Think Tanks, Panels & Oral Presentations)
11:00-11:15am	**Break**
11:15am-12:00pm	**Closing Plenary (Main Auditorium)** **Beyond Dissemination and Implementation Research: Integrating Evidence and Action** Roy Cameron, PhD Executive Director Center for Behavioral Research and Program Evaluation University of Waterloo, Waterloo, Ontario, Canada
12:00-1:00pm	**Lunch (on your own)**
1:00-5:00pm	**Technical Assistance Workshop**

Scientific Advisory Group, Planning Committee and Plenary Speaker List

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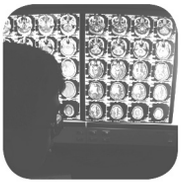
Biosketches






CHRISTINE A. BACHRACH, PHD

Christine Bachrach, PhD, is the Acting Associate Director for Behavioral and Social Sciences Research at the National Institutes of Health and Acting Director of the Office of Behavioral and Social Sciences Research at the NIH. Prior to assuming this role, she served as Chief of the Demographic and Behavioral Sciences Branch at the Eunice Kennedy Shriver National Institute of Child Health and Human Development. A demographer by training, Dr. Bachrach received her Masters in Sociology from Georgetown University and her Ph.D. in Population Dynamics from John Hopkins University. Her scientific interests and publications span the areas of fertility, family formation, marriage and divorce, adoption, sexual behavior, contraceptive practice, and survey methodology. Notable activities at NIH have included oversight of the National Longitudinal Study of Adolescent Health (Add Health), co-chairing the 2000 NIH Conference, "Toward Higher Levels of Analysis: Progress and Promise in Research on Social and Cultural Dimensions of Health", and co-chairing the Social Environment Working Group of the National Children's Study. She has been Vice-President of the Population Association of America, has chaired the Sociology of Population Section of the American Sociological Association, and serves on the Editorial Board of *Journal of Marriage and Family.*

JOSÉ M. BELIZÁN, MD, PHD

José Belizán, MD, PhD, is an obstetrician and epidemiologist focusing his area of research and training mainly in Latin America (LA). He has participated in numerous major perinatal trials mostly in LA. He is the former director of the Pan American Health Organization's/WHO, Latin American Center for Perinatology in Montevideo, Uruguay and is currently the chair of the Department of Mother and Child Health Research at Institute of Clinical Effectiveness in Buenos Aires, Argentina.

Dr. Belizán is an adjunct professor in the Tulane Department of Epidemiology and has been extensively involved in teaching, including the development of a master's course and several short-term courses on the methodology of research training for approximately 1,000 health care professionals from 18 Latin America countries.

AHMED CALVO, MD, MPH

Ahmed Calvo, MD, MPH, is Medical Officer and Acting Deputy Director, Center for Quality, Office of the Administrator, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. He is primarily responsible for accelerating and disseminating lessons learned from the HRSA Health Disparities Collaboratives, by evolving a patient-centered, interdisciplinary integration collaborative approach to seek improvement of the care coordination of the comprehensive health home and related community of practice. As Chief of the Clinical Quality Improvement Branch, Division of Clinical Quality, Bureau of Primary Health Care, Dr. Calvo led the national evidence-based systems efforts for improving quality in the delivery of primary health care provided by federally funded health centers. Previously, Dr. Calvo was Chief Medical Officer of the San Ysidro Health Center, a large federally qualified health center network on the US/Mexico Border; Director of Medical Education and Medical Director at Scripps Memorial Hospital in Chula Vista, in the County of San Diego, California; and on the clinical faculty in the Department of Family and Preventive Medicine at the UCSD School of Medicine. He attended Stanford University, the UCSF School of Medicine, the SDSU School of Public Health, and also completed fellowships at UCSD and at the Wagner School of Public Service with the National Hispanic Medical Association.

ROY CAMERON, PHD

Roy Cameron is Executive Director of the Canadian Cancer Society / National Cancer Institute of Canada's Centre for Behavioural Research and Program Evaluation (**CBRPE**), and Professor of Health Studies and Gerontology, University of Waterloo. He trained at the University of Waterloo (MA, English; PhD, Clinical Psychology) and Duke University Medical Center (Internship).

CBRPE's mission is "to build capacity for, and to conduct social and behavioural studies that contribute to improved cancer prevention and care at a population level." In essence, **CBRPE** is developing infrastructure, analogous to clinical trials networks, to support population intervention studies and related knowledge use across Canada and beyond.

Roy's career has focused on tobacco control research. He is now concerned primarily with building population intervention research capacity in Canada. The goal is to enable the generation and use of timely, relevant, rigorous evidence to inform and continually improve population level policies and programs that a) prevent cancer (and other diseases), and b) improve the quality of life of people affected by cancer.

Roy has helped to instigate a number of initiatives, including the Canadian Tobacco Control Research Initiative (sponsored by CIHR, Health Canada, the Canadian Cancer Society and the National Cancer Institute of Canada to fund population intervention studies), and Population Health Intervention Research Initiative for Canada (led by the CIHR Institutes of Population and Public Health, and Nutrition Metabolism and Diabetes; the Public Health Agency of Canada,; the Chronic Disease Prevention Alliance of Canada; the Canadian Population Health Initiative; and **CBRPE**).

DAVID CHAMBERS, DPHIL

David Chambers, DPhil, is Chief of the Services Research and Clinical Epidemiology Branch (SRCEB) of the Division of Services and Intervention Research at the National Institute of Mental Health. He arrived at NIMH in 2001, brought to the Institute to run the Dissemination and Implementation Research program within SRCEB, where he manages a portfolio of grants that study the integration of scientific findings and effective clinical practices in mental health within real-world practice settings.

Since 2006, David has also served as Associate Director for Dissemination and Implementation Research, leading NIH initiatives around the coordination of dissemination and implementation research in health, and has served as Institute representative to the Federal Action Agenda Executive Committee, which directs the Federal response to the President's Freedom Commission Report on Mental Health. Prior to his arrival at NIMH, David worked as a member of a research team at Oxford University, where he studied national efforts to implement evidence-based practices within healthcare settings.

REDONNA K. CHANDLER, PHD

Redonna K. Chandler, Ph.D. is currently the Chief of the Services Research Branch at the National Institute on Drug Abuse. She has provided leadership and developed initiatives seeking to improve the quality of the drug abuse treatment system with a special emphasis on implementation science and research. Before assuming this position in 2006, she served as the Deputy Branch Chief and Health Scientist Administrator for the Services Research Branch. Prior to joining NIDA, she worked for the Bureau of Prisons implementing, and evaluating evidence-based substance abuse treatment programs for federally sentenced offenders. Dr. Chandler was trained as a psychologist and received her doctoral degree from the University of Kentucky. She has published peer-reviewed articles and book chapters on a range of topics including measuring treatment process and outcomes, treating offenders with substance abuse disorders, addressing co-occurring substance abuse and mental health disorders, and substance abuse problems of adolescent girls. As a licensed psychologist she is an active member in the American Psychological Association and has served as an officer for the Society for the Psychology of Women.

KAREN M. EMMONS, PHD

Karen M. Emmons, Ph.D., is a Professor of Society, Human Development, and Health at the Harvard School of Public Health and the Dana-Farber Cancer Institute. Dr. Emmons received her Bachelor's degree from the University of Illinois, and her Ph.D. from the State University of New York at Stony Brook. She is currently the Deputy Director of the Dana-Farber's Center for Community-Based Research, and Director of its Tobacco Control Program. She is also Co-Director of the Dana-Farber/Harvard Cancer Center's Health Communication Core, and the Associate Director of Initiative to Eliminate Cancer Disparities at the Dana-Farber/Harvard Cancer Center.

Dr. Emmons is a clinical psychologist, and has expertise in health communication, and the development and evaluation of behavioral interventions to reduce the risk of preventable disease. Her research has focused on tobacco control and environmental tobacco smoke exposure. She has also conducted a number of NIH-funded studies targeting a variety of preventable cancers, including colorectal cancer, skin cancer, and lung cancer. Her research focuses primarily on community-based approaches to cancer prevention and control among low income and underserved populations and among cancer survivors, with an emphasis on strategies for enhancing motivation for health behavior change. Dr. Emmons' work also includes a focus on the use of health communication technologies to deliver prevention interventions to underserved populations.

LAWRENCE J. FINE, MD, DRPH

Lawrence J. Fine, M.D., Dr. P.H. is the branch chief of the Clinical Applications and Prevention Branch in the Division of Population and Prevention Sciences at NHLBI. Current scholarly interests range from the prevention of coronary heart disease, efficacy studies treatment of hypertension and heart failure, better methods for patient reported outcomes and effectiveness studies of evidence based cardiovascular medicine. Prior to NHLBI he worked at the Office of Behavioral and Social Sciences Research, in the Office of the Director of NIH. Between 1988 and 2001, Dr. Fine spent 14 years with the National Institute for Occupational Safety and Health, (NIOSH) as Acting Director of the Institute and as Director of the Division of Surveillance, Hazard Evaluations, and Field Studies (DSHEFS). NIOSH is one of the centers in the Centers for Disease Control and Prevention (CDC). Dr. Fine was the Director of the Occupational Health Program at the University Of Michigan School Of Public Health from 1985 to 1988. Prior to 1985 he was on the faculties of the University of Michigan and the Harvard School of Public Health. He is board certified in Internal Medicine and Occupational Medicine.

CHRISTOPHER M. GORDON, PHD

Christopher M. Gordon, PhD, was Chief of the Secondary HIV Prevention and Treatment Adherence program at NIMH from July 2000 – July 2005, and in August 2005 became Branch Chief of Secondary HIV Prevention and Translation Research. In November 2008 he added the role of Associate Director for Prevention at NIMH to his responsibilities. This grant portfolio is housed within the Division of AIDS and Health and Behavior Research. His primary duties involve development of new programmatic foci and initiatives, administration of currently funded research, and building scientific collaborations among other institutes, agencies, and community/clinical sites. Dr. Gordon is also a member of the HIV Prevention Trials Network (HPTN) Behavioral Science Working Group, the NIH CFAR Program Steering Committee, and the NIH Behavioral and Social Sciences Research Coordinating Committee.

Dr. Gordon was trained as a clinical psychologist (at Syracuse University). Before coming to NIMH, he worked as a project director for a study which aimed to reduce risk for HIV and substance use problems among persons living with severe mental illness, and was co-investigator on NIAAA-funded research to better understand the role of alcohol use in the context of sexual risk and relationship decision-making.

THOMAS F. HILTON, PHD

Tom Hilton has been involved in organizational research and research administration in both military and civilian contexts for over 30 years. Much of his work has been in the health services research field examining topics central to Industrial/Organizational Psychology such as customer orientation, teamwork, organizational change, quality of care, efficiency, and effectiveness. For the past decade, Tom has been the program official for NIDA's organizational and management sciences portfolios. In FY 2009, Tom initiated a new portfolio focusing on addiction recovery which examines the ways patients interact dynamically with service organizations and systems of care in ways that help to sustain abstinence from alcohol, tobacco, and illicit drugs. The new *Recovery Portfolio* currently includes longitudinal studies, recovery service studies, patient-reported outcomes measurement techniques, and service models. New projects will include the application of dynamic models as tools for guiding the implementation of service practice enhancements, as well as finding ways to improve the interface between systems of care and patient characteristics such as neurological and physical health status. Most grants addressing research methods and measurements will also remain in the portfolio.

MARK C. HORNBROOK, PHD

Mark C. Hornbrook, PhD, serves as Chief Scientist at The Center for Health Research (TCHR). In this position he leads TCHR's overall scientific program, which has a 45-year history of conducting cutting-edge health research and spans three geographic locations—Hawaii, the Southeast, and the Northwest. Dr. Hornbrook is a health economist with extensive experience collecting, managing, and analyzing large databases. He is a recognized expert in cost and utilization analysis, illness episode grouping methods, economic evaluation methods, patient classification methods, health status measurement, predictive modeling, and health-based remuneration systems. Dr. Hornbrook is the Principal Investigator of the Coordinating Center for the Centers for Research on Therapeutics (CERTs), a high-profile program across 14 sites sponsored by the Agency for Healthcare Research and Quality. Dr. Hornbrook currently serves as Co-Principal Investigator of the Cancer Research Network, a consortium of 14 HMOs working together to find effective ways to prevent and treat cancer. He is Principal Investigator for CDC-funded studies of maternal morbidity rates and amyotrophic lateral sclerosis/other motor neuron diseases in managed care settings. He serves as a Co-Investigator on an NCI-funded study of long-term survivors of colorectal cancer with and without intestinal stomas. He is also a site Principal Investigator for the NCI-funded Cancer Care Outcomes Research and Surveillance Consortium. He is a member of the Oregon Health & Science University's (OHSU) Cancer Institute and serves as Chair of the OHSU/Kaiser Permanente Northwest Cancer Translational Population Research Committee. He is a member of the Academy of Scientists of the Oregon Clinical and Translational Research Institute, one of the initial 12 Clinical and Translational Science Awards. Dr. Hornbrook was recently appointed to a three-year term on the U.S. National Committee for Vital and Health Statistics. Over its 55-year history, the Committee has stimulated a host of improvements in national and international health data and statistics, including disease classification, health surveys, uniform health data sets and other data standards, data needs for minority and other special populations, mental health statistics, state and community health data needs, and privacy protection for health information. Dr. Hornbrook was named a Fellow in the Association for Health Services Research (AcademyHealth) in 1996.

KAREN HUSS, PHD, RN, APRN-BC, FAAN, FAAAAI

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Dr. Huss received a B.S.N., M.S.N., and certificate from the Post-Master of Science in Nursing, Adult Nurse Practitioner Program from the University of Maryland School of Nursing, a PhD, from The Catholic University of America, and a post-doctoral fellowship at the Johns Hopkins University School of Nursing. She also served in the U.S. Army.

Prior to her appointment at NINR, Dr. Huss was Associate Professor at the Johns Hopkins University School of Nursing. She held joint appointments at the School of Medicine and Bloomberg School of Public Health, Department of Environmental Health Sciences. She is a Fellow of the American Academy of Nursing and American Academy of Asthma, Allergy, and Clinical Immunology.

While at NINR in 2004 Dr. Huss co-chaired an invitational 2-day working group meeting, Increasing Opportunities in Biobehavioral Research Expert Working Group using Allergic bronchopulmonary aspergillpsis as a framework. The outcome of this meeting was an Executive Summary and she co-authored a paper titled, "Using rare diseases as models for biobehavioral research: Allergic bronchopulmonary aspergillosis". In July 2008 Dr. Huss co-chaired a 1 ½ day Workshop, Integrating Cost Effective Analysis into Clinical Research.

JIM YONG KIM, MD, PHD

Dr. Jim Yong Kim holds appointments as François Xavier Bagnoud Professor of Health and Human Rights at the Harvard School of Public Health and Professor of Social Medicine at Harvard Medical School. He is Chief of the Division of Global Health Equity at Brigham and Women's Hospital, a major Harvard teaching hospital; Director of the François-Xavier Bagnoud Center for Health and Human Rights; and Chair of the Department of Global Health and Social Medicine at Harvard Medical School. Previously, he was director of the WHO's HIV/AIDS department. Dr. Kim received his undergraduate degree from Brown University, his medical degree from Harvard Medical School, and his Ph.D. in anthropology from Harvard University. He is a founding trustee and the former executive director of Partners In Health, a not-for-profit organization that supports a range of health programs in poor communities around the world. A member of the Fogarty International Center's Advisory Board and the Institute of Medicine, Dr. Kim has also received a MacArthur "Genius" Award and was selected as one of *Time* magazine's 100 most influential people.

LINDA KUPFER, PHD

Dr. Linda Kupfer is currently the Acting Director of the Division of International Science Policy, Planning and Evaluation at the Fogarty International Center (FIC), NIH. She directs strategic planning and evaluation at Fogarty. Investment in implementation science to advance global health is a goal in the new Fogarty Strategic Plan and Linda is part of a team at Fogarty developing and leading this effort. From 2005-6, Dr. Kupfer was the Acting Director of the Evaluation Branch in the Office of the NIH Director.

Dr. Kupfer obtained her BA from Cornell University and her Ph.D. in Pharmacology from Columbia University. She was a AAAS Diplomacy Fellow at the State Department in 1984 and remained at State until 1987. From 1989-2001, Linda worked at NOAA (National Oceanic and Atmospheric Administration), initially working in the agency's International Activities Office and finally as Program Director of the marine biotechnology extramural program in the National Office of the National Sea Grant College Program.

XINGZHU LIU, MD, PHD

Xingzhu Liu is program officer at the National Institutes of Health/Fogarty International Center in Bethesda, Maryland. He has more than 20 years of experience in health economics and public health. Prior to joining FIC in 2007, he was principal scientist with Abt Associates Inc. He was a Global Leadership Fellow in Health with the World Health Organization and was professor and director of the Institute of Social Medicine and Health Policy, Shandong University, China. He initially trained in medicine (MD) and public health (MPH—epidemiology, statistics, demographics) and then in health economics and policy (PhD). His work experience includes applications of generic knowledge and skills (survey research, database management, statistical analysis, cost-effectiveness and cost-benefit analysis, monitoring, and evaluation) to public health issues (health care reform, health care financing, human resources in health, maternal and child health, and various disease control programs, such as HIV/AIDS, tuberculosis, and malaria). He has published extensively and been a principal investigator of 20 research projects in the area of health economics and health policy research.

RACHEL J. MANDAL, MSC

Rachel J. Mandal, M.Sc., has been a Program Analyst in the Office of Behavioral and Social Sciences Research since May 2008. She came to the NIH from The Lineberger Comprehensive Cancer Center at The University of North Carolina at Chapel Hill, where she worked on the Health eCommunities project, a study on the impact of participation in cancer-related listservs on cancer patients, survivors and caregivers. Prior to that, she was a senior research associate at The Federal Reserve Bank of St. Louis.

Rachel Mandal received her M.Sc. in Health, Population and Society from The London School of Economics and Political Science and her B.A. in Economics from Wesleyan University.

DONNA JO MCCLOSKEY, PHD, RN

Dr. McCloskey comes to NCRR from NINR where she was the Director of Training for the Intramural Research Program. She began her career at the NIH in 1985 and for 7 years she worked in the Cardiac Catheterization Laboratory in the Critical Care division of the Clinical Center Nursing Department. Over the next 13 years at the NIH, she held a research nursing position in the Hematology section of the Department of Laboratory Medicine. As a Research Nurse Specialist, Dr. McCloskey began developing a portfolio of research focused on the thrombotic complications associated with venous access devices.

Dr. McCloskey has conducted, supported, and published her research in national as well as international journals on research to improve venous access devices and related thrombotic complications. Past accomplishments include being the recipient of the 1997 Nursing Research Award and the 1998 Distinguished Nurse Award at the National Institutes of Health.

Dr. McCloskey was born in Maine and has lived in the Northern Virginia area since 1973. Dr. McCloskey has been a professional registered nurse since 1977 graduating with an associate degree in nursing from Northern Virginia Community College in Annandale Virginia. Dr McCloskey went on to further her education and graduated with a Bachelor of Science in Nursing from Marymount University in Arlington Virginia in 1983. Dr. McCloskey graduated from the George Mason University in Fairfax Virginia with a Masters Degree in Arts and Sciences concentrating on research design and interpretation in May 2000 and received an award for Outstanding Thesis. Dr. McCloskey received her Doctorate of Philosophy in Nursing from the George Mason University May, 2005.

HELEN I. MEISSNER, SCM, PHD

Helen Meissner, ScM, PhD was recently named senior advisor in the NIH Office of Behavioral and Social Sciences Research (OBSSR) where she is responsible for public health and population science based initiatives. Prior to joining OBSSR in October 2008, Dr. Meissner served as chief of the National Cancer Institute's Applied Cancer Screening Research Branch where she provided scientific leadership in support of social, behavioral and communications research to promote the use of effective cancer screening tests in both community and clinical practice.

Dr. Meissner's research interests include psychosocial, socioeconomic and environmental influences on health outcomes, development of methods and refinement of measures to improve evaluation of behavioral and population-based interventions and approaches to eliminating health disparities. She has over 60 peer-reviewed publications, and serves as an associate editor for *Cancer Epidemiology Biomarkers and Prevention*. Dr. Meissner has served on many NIH, scientific and professional organization committees including the NCI Extramural Advisory Board and the American Association for Cancer Research Task Force on Behavioral Science. She has been recognized with four NIH Merit Awards, a Public Health Service Special Recognition Award and a Department of Health and Human Services Special Service Award.

Prior to joining NCI in 1988, Dr. Meissner was employed at the American Public Health Association where she provided technical assistance to State and local health departments in their efforts to plan, implement and evaluate community preventive health services programs.

Dr. Meissner received both her Sc.M in Public Health Education and her PhD in Social and Behavioral Sciences from the Johns Hopkins Bloomberg School of Public Health.

J. LLOYD MICHENER, MD

J. Lloyd Michener, MD, is Professor and Chairman of the Department of Community and Family Medicine, and Director of the Duke Center for Community Research. Dr. Michener is also President of the Association for Prevention Teaching & Research, past Chair of the Council of Academic Societies, a member of the Board of Directors of the Association of American Medical Colleges, and a member of the Board of the Association of Departments of Family Medicine. In addition, Dr. Michener serves as co-chair of the NIH's Community Engagement Steering Committee for the CTSA awards; a member of the CDC Foundation Working Group on Public Health and Medical Education; the National Institutes of Health Fogarty/Ellison Fellowship Program Selection Committee; and director of the Duke/CDC program in primary care and public health of the American Austrian Foundation - Open Medical Institute.

He has a long standing interest in community health, prevention, informatics, and training of faculty. As Chair of the Department, he leads the family medicine, preventive/occupational medicine, community health, informatics, and physician assistant and physical therapy programs. In addition, with the award of the NIH-funded Clinical and Translational Award to Duke in 2006, he directs a new Center in Community Research that spans the Health System. He also coordinates the institutional chronic disease programs, and oversees the Masters Program in Clinical Leadership, a joint program of the Schools of Medicine, Nursing, Business, Law, and the Institute of Public Policy. Finally, within North Carolina, Dr. Michener has managed the state-wide networks of chronic disease prevention programs of the Kate B Reynolds Charitable Trust and the NC Health and Wellness Trust Fund.

BRIAN S. MITTMAN, PHD

Brian Mittman, PhD is Director of the VA Center for Implementation Practice and Research Support and Senior Social Scientist at the VA/UCLA/RAND Center for the Study of Healthcare Provider Behavior, both at the VA Greater Los Angeles Healthcare System. He served as a Visiting Professor in the Department of Health Services, UCLA School of Public Health from 2003-2006 and taught at the UCLA Anderson Graduate School of Management (Visiting Lecturer to Visiting Associate Professor) from 1986 to 1993. His research interests include implementation science, healthcare quality improvement and healthcare management. He chaired the ad-hoc planning committee that launched the new journal Implementation Science (www.ImplementationScience.com) and serves as co-editor in chief of the journal. From 2002-2004 he served as interim associate director of VA's Health Services Research and Development Service, directing VA's Quality Enhancement Research Initiative (QUERI).

He was a member of the Institute of Medicine Forum on the Science of Quality Improvement and Implementation (2006-2008) and is a consultant and member of the Editorial Board for the AHRQ Health Care Innovations Exchange, a new initiative to classify innovative strategies to increase implementation of evidence-based clinical practices and enhance the efficiency and effectiveness of healthcare delivery. He was a member of the NIH review committee (Special Emphasis Panel) on Dissemination and Implementation Research in Health in June 2006 and chaired the Panel in March and October 2007. His published research appears in the Journal of the American Medical Association, Annals of Internal Medicine, Medical Care, Health Services Research, and other journals, and he is a frequent speaker to US and international audiences on implementation research.

IRENE PRABHU DAS, PHD

Dr. Prabhu Das serves as the Health Sciences Specialist in the Outcomes Research Branch of the Applied Research Program within the Division of Cancer Control and Population Sciences (DCCPS) at NCI. Her primary responsibility involves the evaluation oversight of the NCI Community Cancer Centers Program (NCCCP) pilot initiative that is implemented in diverse geographic areas to improve both research infrastructure and clinical care organization. Focus areas include quality of care-related issues and assessing the pilot program's sustainability and replication potential. Prior to this position, since July 2006, she was the Public Health Advisor on the Designing for Dissemination Team within the DCCPS. Her main focus involved the programmatic oversight of the Cancer Control P.L.A.N.E.T., a jointly-sponsored web portal that provides resources for evidence-based program planning in cancer prevention and control; research dissemination with an emphasis on cancer survivorship and epidemiology as well as computer-tailored interventions; dissemination and implementation research; evaluation; and building research/academic-practice partnerships. Before coming to the NCI, Dr. Prabhu Das served as the Director for the Division of Cancer Prevention and Control, at the South Carolina Dept of Health and Environmental Control, overseeing the Partnership Program of the National Cancer Institute/Cancer Information Service (NCI/CIS), directing the CDC-funded Comprehensive Cancer Control Program as well as the South Carolina Breast & Cervical Cancer Early Detection Program (SC-BCCEDP). Dr. Prabhu Das began her career in cancer prevention and control at the UCLA Jonsson Comprehensive Cancer Center working on breast and cervical cancer research studies. She obtained her Ph.D. in Health Promotion, Education, and Behavior from the University of South Carolina, and her MPH from the University of California, Los Angeles in Epidemiology.

EDUARDO SIMOES, MD, MSC, MPH

Dr. Eduardo Simoes received his medical degree from Faculdade de Medicina, Universidade de Pernambuco in 1981, his Master of Science in Community Health and Diploma of Hygiene and Tropical Medicine from the London School of Hygiene and Tropical Medicine, University of London in 1987, and Master of Public Health from Emory School of Public Health, Emory University in 1991.

In 1982, Dr. Simoes began his career in medicine as a general practitioner. In 1984 -1989, Dr. Simoes served as the District Medical Officer and Program Planner in the Secretariat of Health of Recife and Coordinator of Research in the Secretariat of Education of Pernambuco, Brazil. In 1991-1993, Dr. Simoes was a Visiting Associate with the Division of Nutrition at the Centers for Disease Control and Prevention (CDC). In the Missouri Department of Health, Dr. Simoes served as the Chief Chronic Disease Medical Epidemiologist from1996-2000 and as the Chief, Office of Epidemiology and State Epidemiologist from 2000-2003. He was also Assistant Professor in the School of Public Health, Saint Louis University (1995 – 2003) and an Adjunct Assistant Professor in the School of Medicine, University of Missouri (1996 – 2003). Since February, 2003 he has been the Director of the Prevention Research Centers Program at CDC.

Dr. Simoes has consulted and contributed to public health projects in collaboration with CDC and other national (DHPE, NCCD, ASPH) and international agencies (UNICEF, PAHO, World Bank). Dr. Simoes has designed and implemented more than forty epidemiological studies with public health practice applications resulting in over sixty publications in scientific journals.

KURT C. STANGE, MD, PHD

Kurt C. Stange, MD, PhD is a practicing family physician and epidemiologist. At Case Western Reserve University he is the Gertrude Donnelly Hess, MD Professor of Oncology Research, and Professor of Family Medicine, Epidemiology & Biostatistics, Oncology and Sociology. Dr. Stange is an American Cancer Society Clinical Research Professor. He serves as editor for the *Annals of Family Medicine*, and directs the multi-site Center for Research in Family Practice and Primary Care, one of three research centers funded by the American Academy of Family Physicians. Dr. Stange is actively engaged in ongoing basic and applied research that aims to understand the core structures and processes of primary care practice and their effect on preventive service delivery and patient outcomes, and to discover new methods of enhancing the comprehensive, integrative and relationship-centered generalist approach to patient care. He is a Past-President of the North American Primary Care Research Group, and is a member of the Institute of Medicine of the (US) National Academy of Sciences.

JENNIFER BROWN URBAN, PHD

Dr. Urban is a Society for Research in Child Development (SRCD)/American Association for the Advancement of Sciences (AAAS) Fellow. Dr. Urban received her doctorate in Human Development at Cornell University and her Bachelor's degree in Psychology and Child Development at Tufts University. At Cornell, her research examined how involvement in youth development programs and other out-of-school activities differentially affects the developmental trajectories of youth living in resource rich versus resource poor neighborhoods. Dr. Urban's second line of research focuses on the effective integration of research, practice, and policy specifically through program evaluation and planning. This research is funded through the National Science Foundation and applies systems thinking and evolutionary concepts to the development of evaluation systems in the context of STEM (science, technology, engineering, mathematics) education. After her fellowship year, Dr. Urban will begin her appointment as an Assistant Professor in the Department of Family and Child Studies at Montclair State University.

CYNTHIA A. VINSON, MPA

Cynthia Vinson is the Dissemination and Diffusion Coordinator for the Division of Cancer Control and Population Sciences (DCCPS) at the National Cancer Institute (NCI). In her current position she is responsible for working both within NCI and with other agencies and organizations at both the national, state and local level to translate research funded by DCCPS into practice. In this capacity she has worked to develop and implement the Cancer Control P.L.A.N.E.T. (Plan, Link, Act, Network with Evidence-based Tools) web portal. She is also a representative from NCI to the National Partners for Comprehensive Cancer Control which works with states, tribes, territories and jurisdictions to design and implement evidence-based comprehensive cancer control plans and programs.

She came to work for NCI as a Presidential Management Intern in 1998. Prior to working at NCI, she spent 2 years as a Peace Corps volunteer in Gabon, Central Africa implementing health education and outreach programs for women and children. Ms. Vinson earned a Masters degree in Public Administration from Rutgers, the State University of New Jersey in 1998 with a focus on international development and is currently working on her Ph.D. in Public Policy and Administration at George Washington University.

MADELEINE F. WALLACE, PHD

Dr. Madeleine Wallace is the Acting Chief of the Evaluation Branch in the Division of Program Coordination, Planning, and Strategic Initiatives in the Office of the Director at the National Institutes of Health (NIH). She provides expert advice and guidance on the evaluation of basic and clinical biomedical programs and trans-NIH initiatives. Her expertise is in the field of dissemination and implementation research. While working at the National Heart, Lung, and Blood Institute, she evaluated the approaches and strategies for adapting science-based heart-health information into practical health education messages that met the cultural and contextual needs of diverse groups. Prior to joining NIH, Dr. Wallace led strategic planning efforts to design and evaluate local and state health programs and initiatives. She has given numerous presentations and trainings on her conceptual framework and methodology for adapting and tailoring evidence-based interventions to real-world practice settings. Dr. Wallace earned her Ph.D. in Sociology with a concentration in Demography and Statistics at the University of Tennessee.

LINDA WRIGHT, MD

Linda Wright, M.D., is a pediatrician and neonatologist at the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) and an Adjunct Professor at George Washington University. Her special interests are in research to improve the outcome of very-low-birth-weight infants, especially cognitive outcome; research to improve the health of women and children in the developing world, and building research capacity in the developing world. As Director of two large cooperative agreements, the NICHD Neonatal Research Network and the NIH Global Network for Women's and Children's Health Research, Dr. Wright has been involved in more than 50 large trials and studies which helped transform neonatology into an evidence-based specialty. She has been involved in dissemination and implementation research throughout her NIH career: she planned the U.S. Consensus Conference "Effect of Antenatal Corticosteroids for Fetal Maturation on Perinatal Outcomes," which dramatically changed obstetric practice and has worked to put misoprostol on the WHO Essential Drug List to prevent postpartum hemorrhage. The Global Network, a consortium of seven pairs of US and developing world sites on three continents, was funded to conduct collaborative research to create scientific capacity and sustainable research infrastructure to address the major causes of maternal morbidity and mortality in the developing world. The GN recently completed a cluster-randomized trial of two types of neonatal resuscitation training that trained >3,500 birth attendants to attend >100,000 neonates. The Global Network is currently instituting vital registries of 100 clusters in seven countries, conducting a trial of a package of interventions to improve Emergency Obstetric and Neonatal Care and a trial to improve complementary feeding to promote infant growth and cognitive outcome.

Plenary Session Abstracts

Plenary Session Abstracts

JANUARY 28, 2009; 3:45-5:15PM PANEL

Dissemination and Implementation Infrastructure: Perspectives from CTSA, CDC, HRSA, NICHD, HMORN

Moderator: Donna Jo McCloskey, PhD, RN
National Center for Research Resources

Panelists: J. Lloyd Michener, MD
Clinical and Translational Science Awards (CTSA)

Mark C. Hornbrook, PhD
HMO Research Network

Ahmed Calvo, MD, MPH
Health Resources and Services Administration (HRSA)

Eduardo Simoes, MD, MSc, MPH
Centers for Disease Control and Prevention (CDC)

Linda Wright, MD
The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)

This panel session will provide participants with examples of infrastructure needed for successful dissemination and implementation efforts. Perspectives from a variety of programs will be provided by panels members from the Centers for Disease and Control and Prevention, The NIH Clinical and Translational Science Awards, Health Research Services Administration, Eunice Kennedy Shriver National Institute of Child Health and Human Development, and the HMO Research Networks.

CLOSING PLENARY

Beyond Dissemination and Implementation Research: Integrating Evidence and Action

Roy Cameron, PhD

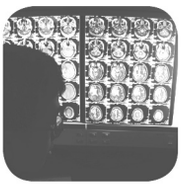
The Centre for Behavioural Research and Program Evaluation (CBRPE), funded by the Canadian Cancer Society, is building a Canadian enterprise that helps prevent disease at a population level by better integrating evidence and action.

The real world, not the literature, is our primary reference point. Our premise is that the major (social/behavioural) experiments in disease prevention will not be done by researchers, but by social actors (e.g., leaders in policy, program, advocacy, and social mobilization). They have policy levers, resources, and influence required to effect novel, sustainable population level interventions.

These social actors shaped our plans. They indicated CBRPE could add most value by helping to *accelerate the generation and use of evidence in developing and implementing effective population health interventions.* They recommended *"specializing in evaluation science to generate contextually sensitive practice-based evidence and related research methods (given the dearth and critical importance of such evidence)."*

We are building capacity to study "natural experiments" as innovative policies and programs are implemented. The goal is to learn as we go what works, for whom, in what context, at what cost, thus enabling ongoing learning and improvement. This necessitates building a) teams spanning research and policy/program sectors, to jointly plan, do and act on, pertinent studies, and b) data systems that enable integration of research, evaluation, policy and practice. Despite challenges, momentum is building. Progress would be facilitated by systemic change in research funding and academic reward structures to enable learning from innovation.

Concurrent Session List






Concurrent Session List

January 28, 2009
Concurrent Session I
9:45am - 11:15am

I. **RANDOMIZED IMPLEMENTATION TRIAL DESIGNS THAT RESPOND TO COMMUNITY AND RESEARCH NEEDS**
Room: Balcony A
Chair: C. Hendricks Brown, PhD, University of South Florida
Session: Panel
Panelists: C. Hendricks Brown, University of South Florida
Jeanne Poduska, American Institutes for Research
Peter A. Wyman, University of Rochester
Individual Presentations:
a. IMPLEMENTATION DESIGN STRATEGIES AND CHALLENGES FOR AN EVIDENCE-BASED PROGRAM
b. COMMUNITY PARTNERSHIPS TO SUPPORT PREVENTION RESEARCH FROM EFFECTIVENESS TO IMPLEMENTATION
c. CUMULATIVE RANDOMIZED TRIAL OF A YOUTH SUICIDE PREVENTION PROGRAM

II. **IMPROVING THE CAPACITY OF CLINICIANS TO DELIVER EFFECTIVE PRACTICES**
Room: Balcony B
Facilitator: David Chambers, DPhil, NIMH
Session: Individual Presentations
a. LINKING DISSEMINATION AND IMPLEMENTATION TO IMPROVE CARE
Presenter: Greer Sullivan, MD, MSPH, South Central VA Mental Illness Research Education and Clinical Center
b. STRATEGIES OF EVIDENCE BASED DECISION MAKING
Presenter: Paul R. Falzer, PhD, VA Connecticut Healthcare System, Clinical Epidemiology Research Center
c. IMPLEMENTING A CLIENT RETENTION INTERVENTION IN A PREVENTION PROGRAM
Presenter: Erin M. Ingoldsby, PhD and David Olds, PhD, University of Colorado Denver

III. **MEASUREMENT**
Room: Balcony C
Facilitator: Irene Prabhu-Das, PhD, NCI
Session: Individual Presentations
a. DISAGGREGATING AND MEASURING IMPLEMENTER ADHERENCE AND COMPETENCE
Presenter: Wendy Cross, PhD, URMC
b. ASSESSING GENERALIZABILITY: CASE STUDY OF PBIS
Presenter: Elizabeth A. Stuart, PhD, Johns Hopkins Bloomberg School of Public Health
c. COMMUNITY PREVENTION: A WEB-BASED EVALUATION/T.A. MODEL
Presenter: Mark E. Feinberg, PhD, The Pennsylvania State University

IV. APPLICATION OF EXTERNAL VALIDITY CRITERIA FOR TRANSLATION RESEARCH

Room: Main Auditorium
Chair: Lisa M. Klesges, PhD, University of Memphis
Session: Panel
Panelists: Paul Estabrooks, PhD, Virginia Tech
Russell E. Glasgow, PhD, Kaiser Permanente Colorado
Lawrence W. Green, DrPH, University of California, San Francisco
Individual Presentations:

a. IMPORTANCE OF AND CRITERIA FOR EVALUATION EXTERNAL VALIDITY
b. EVALUATING EXTERNAL VALIDITY REPORTING IN CHILDHOOD OBESITY STUDIES
c. METRICS FOR COMPARING EXTERNAL VALIDITY DIMENSIONS OF INTERVENTIONS

V. TRAINING THE NEXT GENERATION OF IMPLEMENTATION RESEARCHERS

Room: C1/C2
Session: Think Tank
Chair: Enola Proctor, PhD, Washington University in St. Louis
Discussant: John Landsverk, PhD, Children's Hospital in San Diego
Presenters: Gregory Aarons, PhD, University of California, San Diego
Charles Glisson, PhD, University of Tennessee, Knoxville
Brian Mittman, PhD, VA Greater Los Angeles Healthcare System

VI. USING DYNAMICS MODELING TO FOSTER CHANGE IN PRIMARY CARE PRACTICES

Room: F1/F2
Session: Think Tank
Presenter: David Lounsbury, PhD, Memorial Sloan-Kettering Cancer Center
Discussant: Ralph Levine, PhD, Memorial Sloan-Kettering Cancer Center
Jamie Ostroff, PhD, Memorial Sloan-Kettering Cancer Center
Observer/Recorder: Chetali Gupta, Memorial Sloan-Kettering Cancer Center

VII. CAPTURING, EVALUATING, AND INCORPORATING PRACTICE-BASED EVIDENCE

Room: G1/G2
Session: Think Tank
Discussant: Katherine M. Wilson, PhD, MPH, CHES, Centers for Disease Control and Prevention
Presenters: Teresa J. Brady, PhD, Centers for Disease Control and Prevention
Catherine A. Lesesne, PhD, MPH, Centers for Disease Control and Prevention

January 28, 2009
Concurrent Session II
11:30am - 1:00pm

I. IMPLEMENTATION SCIENCE ISSUES RAISED BY MULTILEVEL INTERVENTIONS

Room: Balcony A

Chair: Margaret R. Weeks, PhD, Institute for Community Research

Session: Panel

Panelists: Marlene Berg, MUP, Institute for Community Research
Jean J. Schensul, PhD, Institute for Community Research

Discussant: Jianghong Li, MD, MS, Institute for Community Research

Individual Presentations:

a. V.I.P. MULTILEVEL INTERVENTION WITH SENIORS TO VACCINATE AGAINST FLU
b. YOUTH ACTION RESEARCH FOR PREVENTION: MULTILEVEL PAR INTERVENTION
c. DRUG USER PEER HEALTH ADVOCATES AS MULTILEVEL CHANGE AGENTS

II. COMMUNITY

Room: Balcony B

Facilitator: Christopher Gordon, PhD, NIMH

Session: Individual Presentations

a. DISSEMINATION OF SCIENCE-BASED PREVENTION BY COMMUNITY COALITIONS
Presenter: Michael W. Arthur, PhD, University of Washington
b. LEVERAGING LOCAL PARTNERSHIPS TO IMPROVE A NATIONAL SYSTEM OF CARE
Presenter: Martha L. Bruce, PhD, MPH, Weill Medical College of Cornell University
c. IMPLEMENTATION OF AN EVIDENCE-BASED INTERVENTION BY 72 CBOS OVER TIME
Presenter: Susan M. Kegeles, PhD, University of California, San Francisco

III. TRAINING

Room: Balcony C

Facilitator: Karen Emmons, PhD, Dana-Farber Cancer Institute and Harvard School of Public Health

Session: Individual Presentations

a. A MODEL OF TRAINING AND TRANSFER OF TRAINING WITH EXAMPLES
Presenter: Wendi Cross, PhD, URMC
b. TRAINING COALITIONS TO ACHIEVE HIGH-QUALITY PROGRAM FIDELITY
Presenter: Abigail A. Fagan, PhD, University of South Carolina
c. STAFF NETWORKS AS A SOURCE OF SKILL TRANSFER TO SUPPORT DISSEMINATION
Presenter: Shoba Ramanadhan, ScD, MPH

IV. CONCEPTUAL MODELS FOR IMPLEMENTATION RESEARCH

Room: Main Auditorium
Chair: Enola Proctor, PhD, Washington University in St. Louis
Session: Panel
Discussant: John Landsverk, PhD, Children's Hospital in San Diego
Panelists: Kimberly Eaton Hoagwood, PhD, Columbia University
Brian Mittman, PhD, VA Greater Los Angeles Healthcare System
Individual Presentations:

a. CONCEPTUALIZING IMPLEMENTATION RESEARCH IN PUBLIC SOCIAL SERVICES
b. MULTI-LEVEL MODELS OF IMPLEMENTATION IN THE DEPARTMENT OF VETERANS AFFAIRS
c. PRACTICAL IMPLEMENTATION RESEARCH WITHIN A STATE POLICY ENVIRONMENT

V. DEFINING TREATMENT INTEGRITY: ADHERENCE AND COMPETENCE IN PRACTICE

Room: C1/C2
Session: Think Tank
Chair/Discussant: Elizabeth Gifford, PhD, Stanford University School of Medicine
Discussant: Ken Weingardt, PhD, Stanford University School of Medicine
Presenters: John Baer, PhD, University of Washington
Nancy Roget, MA, University of Nevada, Reno
Craig Rosen, PhD, Stanford University School of Medicine

VI. EMPLOYING BEHAVIORAL AND SOCIAL SCIENCE TO MEET CHALLENGES IN HEALTH CARE QUALITY IMPROVEMENT

Room: F1/F2
Session: Think Tank
Chair: Denise Dougherty, PhD, USDHHS Agency for Healthcare Research and Quality
Discussant: Lawrence Fine, MD, DrPH, NHLBI
Presenter: P. Jonathan White, MD, USDHHS Agency for Healthcare Research and Quality

VII. PLANNING FOR ADOPTION OF CLINICAL CARE PRACTICES IN GLOBAL HEALTH

Room: G1/G2
Session: Think Tank
Chair: José Belizán, MD, PhD, Institute for Clinical Effectiveness and Health Policy (IECS)
Buenos Aires, Argentina
Facilitator: Marci Campbell, PhD, MPH, RD, University of North Carolina at Chapel Hill
Discussant: Emily Rugel, MPH, Fogarty International Center, NIH
Presenters: James Dearing, PhD, MA, Kaiser Permanente of Colorado
Linda Kupfer, PhD, Fogarty International Center, NIH
Madeleine Wallace, PhD, Division of Program Coordination, Planning, and Strategic Initiatives, NIH

January 28, 2009
Concurrent Session III
2:00pm - 3:30pm

I. **DISSEMINATION OF AN EFFECTIVE SKIN CANCER PREVENTION PROGRAM**
Room: Balcony A
Chair: Karen Glanz, PhD, MPH, Emory University
Session: Panel
Panelists: Cam Escoffery, PhD, MPH, Emory University
Borsika A. Rabin, MPH, Saint Louis University School of Public Health
Individual Presentations:
a. COMPARISON OF TWO DISSEMINATION STRATEGIES FOR IMPLEMENTATION AND MAINTENANCE
b. PROCESS EVALUATION OF POOL COOL PROGRAM IMPLEMENTATION
c. DISSEMINATION OF THE POOL COOL PROGRAM THROUGH LIFEGUARDS

II. **NEW TOOLS FOR DISSEMINATION AND IMPLEMENTATION**
Room: Balcony B
Facilitator: Thomas F. Hilton, PhD, NIDA
Session: Individual Presentations
a. DISTANCE TECHNOLOGIES TO DISSEMINATE HIV PREVENTION PROGRAMS
Presenter: Jeffrey A. Kelly, PhD, Medical College of Wisconsin
b. REGISTRY OF PUBLIC HEALTH KNOWLEDGE TRANSLATION METHODS AND TOOLS
Presenter: Leslea Peirson, MA, PhD, McMaster University
c. A TOOL FOR DEVELOPING RESEARCH KNOWLEDGE TRANSLATION PLANS
Presenter: Suzanne Ross, MA, MBA, Health Policy Strategies, Hamilton, Canada

III. **PROCESS OF DISSEMINATING INTERVENTIONS**
Room: Balcony C
Facilitator: Rachel J. Mandal, MSc, OBSSR
Session: Individual Presentations
a. INFLUENCING EMPLOYER BENEFIT PURCHASING BEHAVIOR
Presenter: Kathryn Rost, PhD, Florida State University
b. ETHNOGRAPHIC DISSEMINATION IN STUDY COMMUNITIES IN MUMBAI, INDIA
Presenter: Stephen L. Schensul, PhD, University of Connecticut
c. PARTNERSHIP RESEARCH: A PRACTICAL DESIGN FOR EVALUATION OF A NATURAL EXPERIMENT
Presenter: Leif I. Solberg, MD, HealthPartners Research Foundation

IV. LINKING PREVENTION SCIENCE AND COMMUNITY ENGAGEMENT IN CHILD WELFARE

Room: Main Auditorium

Chair: Daniel F. Perkins, PhD, Penn State University

Session: Panel

Panelists: Dr. Nick Axford, Dartington Social Research Unit, UK
Brian Bumbarger, Penn State University
Dr. Michael Little, Dartington Social Research Unit, UK

Individual Presentations:

a. AFTER RANDOMISED TRIALS: ISSUES RELATED TO DISSEMINATION OF EVIDENCE-BASED INTERVENTIONS
b. LINKING PREVENTION SCIENCE AND COMMUNITY ENGAGEMENT: A CASE STUDY OF THE IRELAND DISADVANTAGED CHILDREN AND YOUTH PROGRAMME
c. PREPARING THE WAY: FRONT-END WORK TO SUPPORT THE ROLL-OUT OF AN EVIDENCE-BASED INTERVENTION IN SCHOOLS

V. TOWARD THE NATIONAL SCALE-UP OF EFFECTIVE HEALTH PROGRAMS

Room: C1/C2

Session: Think Tank

Chairs: Wynne E. Norton, PhD Candidate, University of Connecticut
Brian Mittman, PhD, VA Los Angeles Healthcare System

Discussants: David Chambers, DPhil, National Institute of Mental Health
Janet Collins, PhD, Centers for Disease Control and Prevention
Denise Dougherty, PhD, Agency for Healthcare Research and Quality
Lori Melichar, PhD, Robert Wood Johnson Foundation
Jed Weissberg, MD, Kaiser Permanente

Presenter: Jim Bellows, PhD, Kaiser Permanente Care Management Institute

VI. CONTEXT: A CHALLENGE TO FIDELITY AND ADAPTATION IN EBP IMPLEMENTATION

Room: F1/F2

Session: Think Tank

Chair/Discussant: Junius J. Gonzales, MD, MBA, University of South Florida

Presenters: Gregory A. Aarons, PhD, University of California, San Diego
Kimberly Eaton Hoagwood, PhD, Columbia University
Phyllis C. Panzano, PhD, Decision Support Services

VII. DESIGNING A RESEARCH TRAINING CURRICULUM IN IMPLEMENTATION SCIENCES

Room: G1/G2

Session: Think Tank

Discussant: Discussant: Sanjay Saint, University of Michigan
Joshua Metlay, University of Pennsylvania

Presenters: Ralph Gonzales, MD, MSPH, University of California, San Francisco
Margaret Handley, PhD, MPH, University of California, San Francisco

January 29, 2009
Concurrent Session IV
9:30am - 11:00am

I. **MODELS FOR IMPLEMENTING AND SUSTAINING EVIDENCE-BASED PROGRAMS**
Room: Balcony A
Chairs: Belinda E. Sims, PhD, NIDA
Aleta Meyer, PhD, NIDA
Jacqueline Lloyd, PhD, NIDA
Session: Panel
Panelists: Abigail H. Gewirtz, PhD, University of Minnesota
J. David Hawkins, PhD, University of Washington
Richard Spoth, PhD, Iowa State University
Individual Presentations:
a. IMPLEMENTING EVIDENCE BASED PREVENTION: LESSONS FROM COMMUNITIES THAT CARE
b. PROSPER PARTNERSHIPS FOR QUALITY IMPLEMENTATION AND SUSTAINABILITY
c. MIDNIGHT SUN TO GREAT LAKES: TAKING PMTO TO SCALE IN NORWAY AND MICHIGAN

II. **EVIDENCE-BASED PRACTICE IN REAL WORLD SETTINGS**
Room: Balcony B
Facilitator: Redonna Chandler, PhD, NIDA
Session: Individual Presentations
a. IMPLEMENTATION OF EVIDENCE-BASED PRACTICES IN CHILD SERVICE SYSTEMS
Presenters: Patricia Chamberlain, PhD, Oregon Social Learning Center
Lawrence Palinkas, PhD, University of Southern California
b. A NATIONAL MODEL FOR FUNDER-RESEARCHER-PROVIDER EBP IMPLEMENTATION
Presenter: Randolph D. Muck, Med, Center for Substance Abuse Treatment
c. IMPLEMENTING HOSPITAL-ACQUIRED INFECTION PREVENTION PRACTICES
Presenter: Sanjay Saint, MD, MPH, University of Michigan Medical School

III. **IMPROVING IMPLEMENTATION QUALITY**
Room: Balcony C
Facilitator: Jennifer Brown Urban, PhD, OBSSR
Session: Individual Presentations
a. A LOW-COST MODEL FOR IMPROVING IMPLEMENTATION QUALITY
Presenter: Brian K. Bumbarger, Penn State University
b. IMPROVING PROGRAM IMPLEMENTATION: CONSUMER PREFERENCE AND OUTCOMES
Presenter: Russell K. Schutt, PhD, University of Massachusetts Boston and Harvard Medical School
c. MARKETING DEPRESSION INTERVENTIONS FOR ADOLESCENTS IN PRIMARY CARE
Presenter: Benjamin W. Van Voorhees, MD, MPH, The University of Chicago Department of Medicine

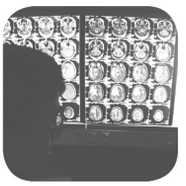
IV. **ONE SIZE DOESN'T FIT ALL: DISSEMINATING TO UNIQUE HIV SERVICE AGENCIES**
Room: Main Auditorium
Chair: Carlo DiClemente, PhD, University of Maryland Baltimore County
Session: Panel
Panelists: Jennifer Betkowski, MA, University of Maryland Baltimore County
Henry Gregory, PhD, University of Maryland Baltimore County
Lisa Jordan-Green, PhD, University of Maryland Baltimore County
Jennifer Prichard, MA, University of Maryland Baltimore County
Jade Wolfman, MA, University of Maryland Baltimore County
Individual Presentations:
a. EMPOWERMENT AND CAPACITY BUILDING IN HIV SERVICE AGENCIES
b. THE ROLE OF CULTURAL COMPETENCE IN DISSEMINATION
c. CASE EXAMPLES IN COLLABORATIVE DISSEMINATION

V. **SYSTEMS THINKING FOR IMPLEMENTATION RESEARCH AND PRACTICE**
Room: C1/C2
Session: Think Tank
Discussant: Jim Bellows, PhD, Kaiser Permanente Care Management Institute
Presenters: Paul Estabrooks, Virginia Tech Riverside
Brian S. Mittman, PhD, VA Greater Los Angeles Healthcare System
Jennifer L. Terpstra, MPH, University of British Columbia
Erica Breslau, PhD, National Cancer Institute
Phyllis C. Panzano, PhD, Decision Support Services

VI. **MONITORING FIDELITY TO TREATMENT MODELS IN LONGITUDINAL DISSEMINATION RESEARCH**
Room: F1/F2
Session: Think Tank
Chair/Presenter: Shannon Wiltsey Stirman, PhD, University of Pennsylvania
Discussant: John Kimberly, PhD, The Wharton School, University of Pennsylvania

VII. **SUSTAINING COMMUNITY MENTAL HEALTH CONSULTATION TO URBAN SCHOOLS**
Room: G1/G2
Session: Think Tank
Chair: Marc S. Atkins, PhD, The University of Illinois at Chicago
Discussant: Kimberly Eaton Hoagwood, PhD, Columbia University

Concurrent Session Abstracts






Concurrent Session Abstracts

January 28, 2009
Concurrent Session I
9:45am - 11:15am

I. RANDOMIZED IMPLEMENTATION TRIAL DESIGNS THAT RESPOND TO COMMUNITY AND RESEARCH NEEDS

Room: Balcony A
Session: Panel

Chair: C. Hendricks Brown, PhD, University of South Florida, hbrown@health.usf.edu

Panelists:

C. Hendricks Brown, University of South Florida
Jeanne Poduska, American Institutes for Research
Peter A. Wyman, University of Rochester

Overview:

While most community-based randomized trials address the question of program effectiveness, there is a growing appreciation of the use of randomized trials to test alternative models of implementation, sustainability, and related questions. This symposium presents three randomized trials of interventions that have varying degrees of evidence. The Multidimensional Treatment Foster Care (MTFC) program, has been classified as meeting the highest level of an evidence-based program, and a new randomized trial is testing two alternative implementation strategies in 40 California counties. The Good Behavior Game (GBG), when delivered to first graders, has been found to be highly effective in reducing aggressive behavior through middle school, alcohol and drug abuse/dependence disorders, conduct and antisocial personality disorder through young adulthood, and school-based mental health and substance abuse services [shorten?]. Newly-funded work is designed to determine sustaining structures for GBG. The Sources of Strength youth suicide prevention program, while not yet fully evaluated, is being tested in a series of randomized trials in three states to simultaneously assess program impact on hypothesized mediators and identify modifications needed to strengthen the program implementation to suit various local conditions. We present both the motivation for these evaluations, community partnerships that are required to support these trials, randomized trial designs and their real-world challenges, and results to date.

Individual Presentations:

a. IMPLEMENTATION DESIGN STRATEGIES AND CHALLENGES FOR AN EVIDENCE-BASED PROGRAM

Authors:

C, Hendricks Brown, University of South Florida (presenter)
Patti Chamberlain Center for Research to Practice,
Wei Wang, University of South Florida
Hyungtae Kim, University of South Florida

Objective: Randomized trials that test two alternative implementation strategies against one another are uncommon and evoke unique challenges. Nevertheless, there are ways of conducting a randomized field trial for testing implementation strategies, and this presentation describes challenges in conducting one county-level randomized trial of an evidence-based program.

Method: We developed a 40 county-level randomized trial to test whether a peer-to-peer model of implementation that was facilitated by a technical support team with experience working with welfare, mental health, and juvenile justice agencies would increase the rate of implementing the Multidimensional Treatment Foster Care (MTFC) program. Counties that had previously been trained in MTFC were excluded so that we could focus on implementation of non-early adopting counties. For the 40 eligible counties in California, we formed 6 equivalent blocks of counties that were matched on county level characteristics. These blocks were randomly allocated to three cohorts and two implementation conditions, an individualized model and a Community Development Team model. Testing took place sequentially for three years across the three cohorts. The primary endpoint was the time it took for the county to meet implementation standards and place a family in foster care.

Results: The design was successfully implemented with no counties opting out of the randomization. A few counties from each implementation arm were unable or unwilling to begin MTFC at their scheduled time, so we developed a strategy to allow for replacement counties without altering the original intervention assignment. We discuss how these real-life challenges affect the design integrity and ability to form causal inferences, and the analysis plan.

Conclusions: This multiple cohort wait-listed design can be used to test alternative implementation strategies for an evidence-based program.

Funding: NIMH and NIDA for methodology and NIMH the California MTFC trial.

b. COMMUNITY PARTNERSHIPS TO SUPPORT PREVENTION RESEARCH FROM EFFECTIVENESS TO IMPLEMENTATION

Co-Authors:

Jeanne Poduska, American Institutes for Research: Presenter
Hendricks Brown, University of South Florida
Wei Wang, University of South Florida
Sheppard Kellam, American Institutes for Research

Introduction: Moving school-based programs with proven effectiveness into widespread practice with fidelity requires partnerships between researchers and multiple school districts and the broader communities in which districts are embedded. These partnerships can ensure that programs are applicable and relevant to school systems and that the system is ready to adopt and scale up these programs as they are proven effective. This presentation describes work in developing a sustaining structure for community-research partnerships that can support efficient, often novel randomized trial designs used to study implementation.

Methods: We are using a formative research framework to support three aims: 1) develop Community Institution Boards within school districts and a Central Coordinating Committee to oversee a multi-site

implementation trial of the Good Behavior Game across school districts; 2) ensure the relevance and acceptance of the systems-level intervention, measures, and design in a subsequent field trial; and 3) identify community and institution level factors that influence program implementation through a combination of qualitative and quantitative methods.

Results: We are working with the American Federation of Teachers and affiliate school districts of Houston, TX and Perth Amboy, NJ, and with Invest in Kids, whose mission is to bring evidence-based programs into practice in the state of Colorado. We discuss the challenges in employing two group-based designs, the multi-cohort wait-list design and the run-in design.

Funding: Scaling-up Prevention Services for Early Drug Abuse Risk in School Systems R21 DA024370

c. CUMULATIVE RANDOMIZED TRIAL OF A YOUTH SUICIDE PREVENTION PROGRAM

Co-Authors:

Peter A. Wyman, University of Rochester (presenter)
C. Hendricks Brown, University of South Florida
Mark LoMurray, Sources of Strength Program, Bismarck, North Dakota

Objective: Widespread implementation of suicide prevention programs by states and local communities provides an opportunity for rigorous evaluation and implementation through collaborative partnerships. We describe the design and initial results from a series of randomized trials in three states designed to simultaneously test program impact and identify modifications needed to strengthen implementation to suit local conditions.

Method: In a first phase, we tested a widely-used 'gatekeeper' suicide prevention program (QPR) using a randomized wait-listed trial with 32 middle/high schools serving 48,000 students in Georgia. We next used a randomized design to evaluate Sources of Strength, a peer-leader training program, in six high schools already trained in a gatekeeper program. In a third, ongoing phase, we are conducting a series of randomized trials of Sources of Strength in schools in New York and North Dakota in diverse underserved communities. The primary outcome is change in norms and behaviors of the student population regarding suicidality. In addition, fidelity of implementation will be evaluated as a function of community and school characteristics.

Results: Gatekeeper training increased school staff knowledge of suicide risk factors and attitudes about engaging suicidal teens but not staff communication with students or identification of suicidal students. For Sources of Strength, we tested 6-month post-training effects in analyses. Training impact was found on positive coping skills and on number of times help was sought from adults at school. Analyses testing impact of Peer Leaders' activities on student norms and behaviors using repeated assessment with students are ongoing.

Conclusions: Adult gatekeeper training had minimal impact on communication with students at school; Sources of Strength increased students' partnering with adults. This series of randomized trials can assess and modify a program as it is implemented by communities.

Funding: NIMH, SAMHSA, Georgia State Legislature and New York Office of Mental Health.

January 28, 2009
Concurrent Session I
9:45am - 11:15am

II. IMPROVING THE CAPACITY OF CLINICIANS TO DELIVER EFFECTIVE PRACTICES

Room: Balcony B
Facilitator: David Chambers, DPhil, NIMH

Individual Presentations:

a. LINKING DISSEMINATION AND IMPLEMENTATION TO IMPROVE CARE

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Dean Blevins, PhD [1, 2]
Michael R. Kauth, PhD [1, 4]

[1] South Central VA Mental Illness Research Education and Clinical Center
[2] Department of Psychiatry, University of Arkansas for Medical Science
[3] Rand Corporation
[4] Menninger Department of Psychiatry, Baylor College of Medicine

Introduction: The South Central (SC) VA Network encompasses an 8-state region, includes 10 medical centers and 37 community clinics; employs more than 1000 mental health providers; and serves about 2 million veterans. Since 2000, the SC MIRECC has coordinated a series of efforts intended to make evidence-based practices (EBPs) more broadly available to patients across the Network. Three sequential studies have informed our conceptual model that links dissemination (effective training in EBPs) to implementation (bringing EBPs into everyday care) such that patients benefit.

Methods: *Study 1* used a quasi-experimental design (5 matched pairs of medical centers) to examine the effect of training in group therapy on the use of group therapy in outpatient treatment settings. *Study 2* used a pre-post design in 9 medical centers to train and implement psychosocial rehabilitation programs with outcomes assessed relative to pre-determined, site-specific implementation goals. *Study 3* is using a quasi-experimental design (6 matched pairs of clinics) to more rigorously test the specific effect of external facilitation on both dissemination and implementation of cognitive behavioral therapy (CBT).

Results: In *Study 1*, despite participation of 136 providers in training, we found no evidence that patients received more group therapy. In *Study 2*, use of an external facilitator to assist both with training and implementation appears to have had a very positive effect on site-specific goals. In *Study 3*, we are more rigorously testing the effects of external facilitation on both dissemination and implementation of CBT.

Conclusions: While a common practice, disseminating clinical skills to providers through intensive training does not necessarily result in improved care for patients and is unlikely to be cost-effective. To assure improved quality of care, we have coupled dissemination and implementation efforts in practice, developing a unified conceptual model that will be described.

Source of Funding: South Central VA Mental Illness Research Education and Clinical Center (SC MIRECC)

b. STRATEGIES OF EVIDENCE BASED DECISION MAKING

Presenter/Primary Contact:

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The importance of clinical decision making has been acknowledged in the current implementation literature, particularly its capacity to contextualize treatment guidelines and apply general knowledge to specific cases. However, studies have not examined how guidelines contribute to the clinical context, which in turn influences treatment decisions. Moreover, studies to date have relied on a conformance standard, when a more appropriate gauge is whether a guideline has been incorporated into clinical decision strategies.

A study is reported that had two principal objectives: 1) to develop and test an incorporation procedure and standard for assessing implementation; 2) to use the procedure in testing the hypothesis that evidence-based practices are incorporated strategically, by applying contextual attributes to specific cases.

The study used a switching guideline for treatment resistant schizophrenia and a stimulus consisting of 64 case vignettes. The stimulus represents a balanced 4x2x2x2x2 within-subjects design, comprised of contextual, guideline, and case-related attributes. Study subjects were a convenience volunteer sample of psychiatric residents. Generalized estimating equations and multivariate linear models tested the hypothesis and examine within-subjects consistency of decision strategies.

Overall endorsement was 42%, and ranged from 1% to 90% when contextual attributes were added. The matching procedure accounted for 62% of within-subject endorsement variance and there was clear evidence of contextualized decision making. The guideline was rejected when the expected result of following it was poor. The guideline was followed inconsistently in a high risk context. Otherwise, the guideline was incorporated consistently into clinical decision strategies.

These results have significant implications for how guidelines can be framed and disseminated more effectively, how clinicians can be trained to use guidelines more systematically and extensively, how the role of guidelines can be more accurately depicted, and how they can better assist practitioners in making difficult decisions, particularly when evidence-based treatment alternatives have limited effectiveness.

c. IMPLEMENTING A CLIENT RETENTION INTERVENTION IN A PREVENTION PROGRAM

Primary Contact:

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Authors:

Erin M. Ingoldsby, Ph.D., Research Fellow (presenter)
David Olds, Ph.D. (co-presenter)
Pilar Baca, RN, MSN
Francesca Pinto, MPH
Dennis Luckey, Ph.D.
Prevention Research Center for Family and Child Health
University of Colorado Denver, Department of Pediatrics

The goals are to: describe the development and testing of an evidence-based retention intervention to improve program completion in the Nurse-Family Partnership (NFP) home visiting program; present the implementation process in a 15-site pilot test and 26-site RCT, funded by the W.T. Grant Foundation, in NFP community replication sites; and facilitate dialogue in which complexities of addressing implementation issues in community practice settings are considered. The retention intervention involved training nurses to more effectively adapt the NFP preventive intervention to clients' needs. Using skills developed from Motivational Interviewing, nurses offered clients options to adapt the frequency, duration, and content of the NFP program. Nurse engagement with the training process (uptake) was assessed by survey and focus groups. Nurses reported whether they delivered the retention intervention to each client (reach) and how much of the NFP basic intervention was delivered (dose, delivery). We found a modest positive impact of the intervention on client retention. Site and nurse implementation of the retention intervention varied widely (e.g., site reach ranged from 48% to 90%). Moreover, nurses who delivered the intervention to a larger portion of their clients (i.e., those with greater reach) retained significantly more clients, and clients who received the intervention were 1.8 times more likely to be retained than non-reached clients. Low reach was generally associated with poorer site functioning (e.g., fewer experienced nurses, low nurse uptake, lower baseline retention). Several potential factors associated with implementation, including nurse beliefs about the efficacy of the approach, dissatisfaction with training structure and time commitment, and competing site demands, emerged in qualitative analysis as possible explanations for this variation. We currently are developing a model to address these issues in another RCT that will lead to improved integration of this innovation in NFP practice.

January 28, 2009
Concurrent Session I
9:45am - 11:15am

III. MEASUREMENT

Room: Balcony C

Facilitator: Irene Prabhu-Das, PhD, NCI

Individual Presentations:

a. DISAGGREGATING AND MEASURING IMPLEMENTER ADHERENCE AND COMPETENCE

Presenter/Primary Contact:

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Karen H. Schmeelk-Cone, PhD

As efficacious programs are transferred to communities, valid and reliable measures of implementer behaviors are essential for studying program delivery. *Adherence* refers to the extent to which implementers use protocols prescribed by the program manual. *Competence* refers to quality demonstrated by the implementer in following the prescribed protocol and includes the extent to which the implementer is sensitive to and incorporates contextual variables in the transaction. Theoretical and empirical reasons to distinguish implementer adherence and competence and to examine the relationship between them are discussed for the following domains: *1) intervention outcome research* (i.e., conflicting findings regarding intervention effectiveness, and the relationship between overall treatment adherence and outcomes, may be accounted for by variations in adherence or competence, or both); 2) *understanding translation of manualized treatment in real world settings* (i.e., very low adherence means the intervention is not being delivered, but strict adherence may be associated with poorer outcomes); 3) *development of evidence-based training and implementation procedures* (i.e., what constitutes 'good enough' adherence to manuals and competence in delivery for positive outcomes, and, what training methods ensure development of those behaviors?). The two constructs—adherence and competence -- are optimally measured through observational ratings of implementers in the field. We describe methods of disaggregating and measuring adherence and competence for a manualized school-based prevention program delivered by highly trained paraprofessional implementers. We present examples of observational rating scales and factor analytic data showing that adherence and competence are related but distinct constructs. Finally we discuss the development of implementer abilities in both domains and ongoing studies using these measures in a randomized controlled study of outcomes of the same school-based prevention program.

Funding: NIMH (MH73615; MH068423)

b. ASSESSING GENERALIZABILITY: CASE STUDY OF PBIS

Presenter/Primary Contact/Author:

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To ensure that the best services are being used to improve public health we need to know that those services are effective across broad populations. Increased emphasis on services that have been evaluated using randomized trials carried out in real-world settings ("effectiveness") is one important step. But the subjects in trials are rarely representative of the target population of interest. A next step is to determine whether the results seen in a trial generalizes to the target population. The objective of this work is to explore methods for assessing generalizability using a unique combination of data: a group randomized trial of Positive Behavior Interventions and Supports (PBIS), a school-wide violence prevention program, embedded within the broader statewide implementation of the PBIS program in schools across Maryland. The trial involved the random assignment of 37 Maryland elementary schools to PBIS or a control condition. We address the question of how the randomized trial of PBIS can inform policy makers about the broader effectiveness of the program statewide. The methods use propensity scores to examine how similar the randomized trial schools are to schools statewide and then weight the trial schools to represent the full set of schools in the state. We lay out the assumptions underlying this approach, being particularly clear about the types of schools to which we can and cannot generalize the findings from the randomized trial. In addition to assisting policy makers in assessing the broader effectiveness of the PBIS program, this work helps to provide a framework for considering the role of randomized trials within questions of broader program effectiveness.

Work supported by Grant K25MH083846-01 from the National Institute of Mental Health

c. COMMUNITY PREVENTION: A WEB-BASED EVALUATION/T.A. MODEL

Presenter/Primary Contact:

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Authors:

Mark E. Feinberg, Ph.D., Prevention Research Center, The Pennsylvania State University
Mark T. Greenberg, Ph.D., Prevention Research Center, The Pennsylvania State University
Richard W. Puddy, Ph.D., Centers for Disease Control

Objective: Community coalitions (CCs) are popular means of disseminating a number of preventive public health innovations and programs. Yet several literature reviews indicate that CCs have labored with some difficulty to demonstrate empirical evidence of implementation fidelity and effectiveness. Training and technical assistance (TA) have been identified as important elements in promoting improved functioning of CCs. We aimed to test the reliability, validity, and usefulness of an inexpensive, web-based assessment of CC functioning, resulting in feedback reports for TA providers to use a springboard for strategic planning with CCs.

Method: We developed a CC web-based questionnaire and feedback report format in the context of Pennsylvania's Communities That Care (CTC) model. A web-based questionnaire was developed and administered to over 79 CCs (N=867 participants) and the validity and reliability were assessed through multiple means, including construct convergence, test-retest data, comparison to TA provider reports, and the use of a companion TA implementation feedback questionnaire completed by TA providers assigned to each of the sites.

Findings: Results indicated adequate to good psychometric properties on internal reliability of the web-based questionnaire, moderate construct validity across different reports of functioning, and relative stability over the course of one year. Measures obtained predicted sustainability of the CCs over time. Evidence also demonstrated that the CC feedback reports were utilized by TA providers to discuss coalition functioning with CC members and foster strategic planning. CCs and TA providers have participated in five annual administrations of the system.

Conclusions: Implications of the relatively low-cost, reliable, and user friendly system for supporting CC effectiveness are discussed. Additionally, areas of application for future research including linking coalition functioning with the quality and nature of technical assistance, levels of risk and protective factors, and large outcome datasets are highlighted.

Acknowledgements: This research has been supported by a series of grants from the Pennsylvania Commission for Crime and Delinquency (PCCD). However, findings and recommendations herein are those of the authors and not official statements of PCCD. We acknowledge the enthusiastic support of Clay R. Yeager, Ruth Williams, Charles Gray, Doug Hoffman, Ray Moneta, Mary Ann Rhodes, Beverly D. MacKereth, and Henry Sontheimer at PCCD in supporting the vision of this project.

January 28, 2009
Concurrent Session I
9:45am - 11:15am

IV. APPLICATION OF EXTERNAL VALIDITY CRITERIA FOR TRANSLATION RESEARCH

Room: Main Auditorium
Session: Panel

Chair:

Lisa M. Klesges, PhD
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Panelists:

Paul Estabrooks, PhD, Virginia Tech
Russell E. Glasgow, PhD, Kaiser Permanente Colorado
Lawrence W. Green, DrPH, University of California, San Francisco

Overview:

In addition to an increasingly rigorous expectation for reporting established internal validity criteria in health research, translational research would benefit from a greater accumulation and weighing of evidence having external validity to drive program planning, health system, and policy decisions. In general, these decisions require reporting of evidence that emphasizes high generalizability to time, place and population characteristics, which combines external validity (EV) and contextual relevance. Also, methods are needed to compare the relative merits of different programs and estimate their potential for significant "real world" public health impact. This panel presentation aims to underscore and address this need for EV criteria.

Three presentations will highlight the need for establishing EV criteria, illustrate their application for evaluating the generalizability of reported research for future translation, and demonstrate EV metrics to describe and contrast approaches to estimating the public health impact of behavior change interventions. The first presentation describes the rationale and importance of establishing EV criteria as well as which aspects of EV reporting are considered most important to support translation of research into practice. The second presentation summarizes a literature review that evaluates the extent to which key EV elements are currently reported in childhood obesity prevention and treatment studies. The third presentation involves an application of summary metric approaches to combining EV elements using the RE-AIM framework to compare worksite health promotion interventions. Illustrations will demonstrate the need for greater depth of reporting of external validity criteria and their application to actual decision-making scenarios in estimating population impact.

The presenters will discuss with the audience the EV criteria for translating research into practice and policy along with strengths and limitations of reporting recommendations and applications of the metric approach.

Individual Presentations:

a. IMPORTANCE OF AND CRITERIA FOR EVALUATION EXTERNAL VALIDITY

Presenter/Primary Contact:

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Established and agreed upon criteria for evaluating the internal validity of health research are widely used for reporting and reviewing research studies. Comparable criteria for reporting of external validity in health research have been suggested, but not yet widely adopted. Practitioners voice concerns about the relevance of most research to their local settings and about the need for more practice-based research. Our purpose is to discuss the feasibility of collecting and reporting on external validity (EV) criteria to help translate research into practice.

Recommendations are made for EV reporting criteria within four categories: 1) Reach and Representativeness includes specification of the intended target audience(s) and the participation rate and representativeness of settings, staff, and individuals in a study. 2) Implementation and Adaptation criteria include consistency of delivery of the program content and consistency of delivery across staff, degree to which delivery is adapted over time, and change in theoretically important mechanisms. 3) Outcomes include the clinical or public health significance of improvements, occurrence of adverse or unanticipated results, whether effects were moderated by subgroups or contextual factors, and cost and sensitivity analyses. 4) Maintenance and Sustainability criteria include long-term effects of individual change, institutionalization of a program, and the impact of attrition.

These EV criteria were presented to a group of 13 health research journal editors who agreed upon the importance of the issues, but not upon whether these reporting criteria should be required. Several journals have either adopted them or published editorials encouraging their use. Increasing the use of these EV criteria in reporting research would improve the quality of future quantitative literature reviews in assessing contextual factors. It would also allow practitioners and local decision makers to determine the applicability of evidence, and researchers and policy makers to evaluate external validity and potential for generalization of program outcomes.

b. EVALUATING EXTERNAL VALIDITY REPORTING IN CHILDHOOD OBESITY STUDIES

Presenter/Primary Contact:

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To determine the need for improvements in how we report health research to support decision-making and translation of evidence to practice, we conducted literature reviews evaluating the extent to which external validity criteria were reported in an extant literature. Specifically, we conducted a systematic review of the childhood obesity literature using external validity dimensions described by Green & Glasgow (2006). The first review evaluated controlled studies of behavioral *treatments* (BT) for childhood obesity published between 1980 and 2004 (n=56); the second review considered childhood obesity *prevention* interventions (PI) during the same period (n=19).

Across both reviews, there were no studies that provided full reports of external validity elements. Few studies reported participation rates (43% of BT; 63% of PI) and fewer (9-10%) reported on representativeness of the children agreeing to participate. Only 2% of BT studies reported setting participation while 22% of PI studies reported setting-level participation. No studies reported site-based representativeness of organizational characteristics. Consistency of intervention delivery was reported by few (11% of BT; 26% of PI studies) with cost of the intervention rarely reported (2% of BT; 0% of PI). About half of the studies reported testing for a robust effect between subgroups (45% of BT; 53% PI) but fewer included reports of potential negative outcomes (20% of BT; 32% PI). A majority of studies (79% of BT; 100% of PI) reported attrition estimates; far fewer (9% of BT; 42% of PI) compared characteristics of those leaving and remaining in the study.

Overall, those elements related to internal validity were reported to a greater extent than those focused on external validity. To improve the evidence base to support translation, more attention to contextual elements and external validity issues is needed. Recommendations and specific suggestions to improve the future translation of intervention research to practice will be offered.

c. METRICS FOR COMPARING EXTERNAL VALIDITY DIMENSIONS OF INTERVENTIONS

Presenter/Primary Contact:

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Authors:

Paul Estabrooks, PhD, George Davis, PhD, & Ranju Baral, MS, Virginia Tech

This presentation reviews Glasgow et al's (2006) proposed methods to combine RE-AIM external validity metrics with the intent to determine their utility for worksite health professionals. Metrics were applied to evaluation of data from 7 worksites (10513 employees) to determine the reach and effectiveness of a weight loss program, while information from 30 worksites (8610 employees) was used to determine setting level representativeness, adoption, and implementation metrics. Reach composite (.88) was computed by subtracting differential recruitment based on age & gender (ES=-.26) from the participation rate (ES=.62). Effectiveness composite (.29) was computed using the resultant of the average effect size (ES=.45) minus the median differential effect sizes of age and gender (ES=.16). Adoption composite (-.41) was calculated by subtracting the median difference in setting characteristics (i.e., size and age of workforce; ES=1.21) from the proportion of worksites approached that agreed to participate (12/15=.80). Finally, 95% of intervention content was successfully implemented with no differences across settings. We calculated individual level impact (Reach * Effectiveness [RE]=.26), setting level impact (Adoption * Implementation [AI]=-.39), and overall RE-AIM impact ((R+E+A+I)/4=0.43). Attributable individual level impact and efficiency were also calculated. RE-AIM calculations were successfully applied in this context, but the meaning of different values and the utility of these metrics outside of research audiences is unclear. These metrics attempt to calculate different probabilities (or frequencies), making adjustments for differences across subpopulations. Closer adherence to the rules of probability may allow for a more interpretable range of scores (i.e., 0 to 1). Further, practical additions such as the proportion and characteristics of the total employee population that ultimately benefited (approximately 10%; Women more likely to succeed), the amount they lost (Mean=9.5 lbs), cost per successful employee ($171), and characteristics of the settings that achieved these results may be more understandable for research and practice professionals.

January 28, 2009
Concurrent Session I
9:45am - 11:15am

V. TRAINING THE NEXT GENERATION OF IMPLEMENTATION RESEARCHERS

Room: C1/C2
Session: Think Tank

Chair:

Enola Proctor, PhD
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Discussant:

John Landsverk, PhD, Children's Hospital in San Diego

Presenters:

Gregory Aarons, PhD, University of California, San Diego
Charles Glisson, PhD, University of Tennessee, Knoxville
Brian Mittman, PhD, VA Greater Los Angeles Healthcare System

Problem: Bold and innovative efforts are required to develop skilled implementation researchers. The field is not ready for typical training approaches in which an established body of knowledge is transmitted by experts. Implementation science remains emergent: methods are underdeveloped; theory is debated, and funding sources and publication outlets are changing rapidly. Implementation science is inherently multidisciplinary, conducted by researchers from a diverse range of disciplines for which implementation issues may not be central. There are few established centers of deep research activity, and no current NIH funded training programs focus specifically on implementation research. New models are needed to inform training for this important field and stimulate the development of new programs.

"Case" and framework: This "think tank" will provide a forum for dialogue about several challenges in training for implementation research. A panel of implementation researchers involved in training will set the stage by presenting a set of challenges, including the still-developing nature of IR as a field, the absence of an established core curriculum, the lack of a "disciplinary home" for IR, the mixed methods required for IR, and sources of support for training in the current grant environment. The panel will briefly offer as a "case study" a template curriculum shaped as a learning collaborative. Proposed methods include didactic teaching and experiential learning, distance learning, and training in observation of agency- and research- implementation efforts.

Discussion will elicit participants' experiences in training for IR, ideas about methodological challenges new researchers will confront, and direction for training program content, structure and infrastructure. Participants will critique curricular models and generate ideas about how to exploit for training the small but growing number of NIH funded implementation research projects. Ideas and recommendations for action will be summarized and reported to the conference program committee and key agencies involved in IR.

January 28, 2009
Concurrent Session I
9:45am - 11:15am

VI. USING DYNAMICS MODELING TO FOSTER CHANGE IN PRIMARY CARE PRACTICES

Room: F1/F2
Session: Think Tank

Presenter:

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Discussant:

Ralph Levine, PhD, Expert in System Dynamics, Memorial Sloan-Kettering Cancer Center
Jamie Ostroff, PhD, Expert in Clinical Tobacco Treatment, Memorial Sloan-Kettering Cancer Center

Observer/Recorder:

Chetali Gupta, Project Assistant, Memorial Sloan-Kettering Cancer Center

In this think tank, we will share our on-going work in applying system dynamics modeling [1-5] as a means to develop a simulation tool that will foster learning about and implementation of the PHS Guideline in small primary care settings. Brief counseling intervention by primary care providers has been shown to effectively promote tobacco cessation, yet many physicians are inconsistent in the way they intervene with their patients [6-8]. Too little time, poor training, lack of third-party reimbursement, competing clinical problems, and the belief that their patients are not able to change also explain why some physicians do not adhere to evidence-based guidelines for treating tobacco use and dependence [9-11]. Throughout the session, we will elicit feedback from participants about our current working model and about the utility of simulating various practice-specific, cost-effective strategies regarding tobacco treatment during an office-based consultation. We anticipate that our simulation tool will help providers answer critical questions such as: What is the effect of providing more counseling time during an office visit? What interventions are most cost-effective for the practice? What if patients who smoke were consistently referred to external resources, such as state quit lines? What mix of counseling and treatment best protects against relapse? We will demonstrate how this tool would allow for quick comparison of alternative ways of changing office procedures by generating scenarios that simulate different combinations of role-sharing or resource exchange. Specifically, we will query participants about how best to present model output to convey a dynamic picture of the costs and benefits of various approaches to tobacco treatment, over time, within a given practice. We will also identify participants' ideas for other health services applications of system dynamics modeling. Our presentation slide set, references, and copious notes from the session will be made available to the program committee.

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January 28, 2009
Concurrent Session I
9:45am - 11:15am

VII. CAPTURING, EVALUATING, AND INCORPORATING PRACTICE-BASED EVIDENCE

Room: G1/G2
Session: Think Tank

Presenter/Primary Contact:

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Discussant:

Katherine M. Wilson, PhD, MPH, CHES, Centers for Disease Control and Prevention

Presenters:

Teresa J. Brady, PhD, Centers for Disease Control and Prevention
Catherine A. Lesesne, PhD, MPH, Centers for Disease Control and Prevention

Authors:

TJ Brady; KW Wilson, CA Lesesne

Bridging the gap between research and public health practice is a critical challenge to the success of public health programs, policies, and practices. While much attention has been focused on translating research-based knowledge into public health practice, much less attention has been focused on gathering and transferring practice-based evidence to the research community. The purpose of this think tank is to stimulate discussion on how best to stimulate, collect, and evaluate practice-based evidence and discovery to inform the research enterprise.

This think tank will use CDC's National Center for Chronic Disease Prevention and Health Promotion's (NCCDPHP) Translation Schematic as the organizing framework. The Translation Schematic is a graphic representation of the essential processes necessary to move scientific discovery into widespread public health practice, and identifies three phases of the translation process: the research phase, translation phase, and institutionalization. Critical elements of the Translation Schematic are feedback loops (Practice-based Discovery and Practice-based Evidence) from practitioners to intervention developers and disseminators.

This session will briefly present the NCCDPHP Translation Schematic, using an evidence-based physical activity intervention, EnhanceFitness, to illustrate. The dilemma to be posed to participants is how to facilitate, collect and evaluate practice-based evidence and discovery or to catalyze dialogue among those developing or disseminating interventions and those responsible for implementing them in the field. Discussion will be structured around two case studies: a packaged intervention program (Chronic Disease Self Management Program), and a public health practice (incorporating HIV counseling and education into family planning clinics). The discussion will explore how researchers and funding agencies can capture practice-based evidence, how the validity of practice-based evidence can be established, and how this practice-based discovery and evidence can be utilized to further inform both research and practice. Key discussion points and recommendations will be captured by the discussion facilitators and submitted to the conference program committee. The discussion will also result in a list of questions about gathering practice-based evidence researchers may want to consider as they develop dissemination or implementation research proposals.

January 28, 2009
Concurrent Session II
11:30am - 1:00pm

I. IMPLEMENTATION SCIENCE ISSUES RAISED BY MULTILEVEL INTERVENTIONS

Room: Balcony A
Session: Panel

Chair/Primary Contact:

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Panelists:

Marlene Berg, MUP, Institute for Community Research
Jean J. Schensul, PhD, Institute for Community Research

Discussant:

Jianghong Li, MD, MS, Institute for Community Research

Overview:

Multilevel community interventions are increasingly called for in prevention science to extend the efficacy and sustainability of prevention efforts. Such interventions are often highly complex in design and implementation procedures, linking or synthesizing several different but related theoretical frameworks and requiring multi-pronged and often non-traditional evaluation approaches. Methodological issues in particular for the measurement of multilevel intervention process and outcomes present many challenges, even in the often controlled settings of initial intervention efficacy research. These issues and complexities become even greater when moving to the stage of implementation, dissemination, and scaling up of such designs in real world contexts. Questions of adaptation, implementation process, and measurement confront research and community partners in efforts to implement multilevel interventions as they were originally tested and designed to be effective.

This panel presents three case examples of multilevel interventions that have shown significant efficacy in community intervention trials and are appropriate for broader implementation and dissemination efforts. The first is designed to increase influenza vaccine uptake among adults in low-income senior housing through peer delivered vaccine campaigns organized by V.I.P. (Vaccinate for Influenza Prevention) Committees of senior housing residents and their community advocates. The second is a substance abuse prevention and positive social development intervention to train teens in participatory action research methods to design and conduct studies of issues they identify and around which they build community action projects. The third is a peer-delivered social network empowerment program to train drug users as Peer Health Advocates to diffuse HIV/hepatitis/STI prevention intervention through their networks and in their communities. Discussion will focus on challenges that arise in preparing these and other multilevel interventions for implementation in various community contexts, questions of adoption/adaptation, feasibility of multilevel implementation and sustainability, and appropriate and feasible measurements of process and outcomes of both the intervention itself and the implementation/dissemination effort.

Individual Presentations:

a. V.I.P. MULTILEVEL INTERVENTION WITH SENIORS TO VACCINATE AGAINST FLU

Presenter:
Jean J. Schensul, Ph.D., Institute for Community Research

Co-Authors:
Emil Coman, Kim Radda, Elsie Vazquez (Institute for Community Research)

Background: *V.I.P.: Vaccinate for Influenza Prevention*, funded by the National Institute on Aging, is a multilevel intervention to improve and sustain flu vaccination rates among low-income/ minority older adults in senior housing.

Methods: A bilingual multiethnic research team partnered with building management, a resident V.I.P. Committee, VNA Health Care Inc., regional flu organizations (the Influenza Strategic Alliance—ISA) and the University of Connecticut Health Center (UCHC). Two senior low income/minority residences of equivalent size (150 units) were randomized to intervention and control conditions. Researchers established desired outcomes with committees and groups. Intervention implementation included building management support for campaign activities, V.I.P. Committee training and delivery of flu campaigns with interactive components and products, and ISA/UCHC scientific support. One VNA flu clinic (standard of care) was conducted in the control building. Desired outcomes evaluated qualitatively or quantitatively included independent involvement of building management in flu vaccination campaigns; independent/interrelated functioning of V.I.P. Committee and ISA, continued resident participation in influenza campaigns, increase in vaccination rates, and expansion of UCHC support for community-based public health research. Pre-/post-intervention surveys assessed changes in residents' vaccination beliefs, knowledge, norms, and prior and current year vaccination status.

Results: Building management independently provided campaign resources; the V.I.P. Committee conducted flu campaigns with residents with minimal support, created pro-vaccination messages, products and dialogue, sustained its work over 2 years and promoted vaccinations elsewhere. The ISA supported the VNA in flu clinics, provided needed insurance-gap resources, and met to expand the study. UCHC provided accurate scientific data and utilized the study to promote increased health center/community collaboration in public health and clinical trials. Pre/post survey results with residents show outcomes improved significantly in the treatment building over control.

Conclusions: This study illustrates promise and problems in implementing a multilevel approach to improve and sustain health behavior change in vulnerable older adults.

b. YOUTH ACTION RESEARCH FOR PREVENTION: MULTILEVEL PAR INTERVENTION

Presenter:
Marlene Berg, M.U.P., Institute for Community Research

Co-Authors:
Emil Coman, Gary Burkholder

Background: The goals of Youth Action Research for Prevention (YARP), a city-wide program with urban adolescents aged 14 – 16 residing in high-risk neighborhoods, uses youth empowerment as the cornerstone of a multilevel research and demonstration project designed to reduce and/or delay onset of drug and sex risk, while increasing individual and community efficacy and educational expectations. YARP was funded by the Center for Substance Abuse Prevention (CSAP) and the Connecticut Department of Mental Health and Addiction Services (DMHAS).

Methods: Youth-led/adult supported structured inquiry, data collection and analysis, self-reflection and practice promote the formation of prevention oriented group norms and improve career and educational expectations. YARP trained 114 African-American and Latino Hartford youth to become paid Youth Researchers through a 7 week intensive Summer Youth Research Institute, a 4-hour per week after-school program during the school year, and educational/career counseling. A longitudinal quasi-experimental design used a self-administered survey to compare three intervention cohorts with a matched sample of Hartford youth at four time points. Process evaluation included ethnographic observation, staff interviews, youth focus groups, youth self-reflection and a network data collection instrument that measured group structure, social cohesion, bonding and interdependence.

Results: Engagement in community activism as has an effect on perceived community efficacy, positive peer norms regarding drug use, and individual behavioral change related to marijuana use and improved educational outcomes.

Conclusion: Results of this three-year study demonstrate that YARP is a viable model for risk reduction among high school adolescents. This approach offers an alternative multilevel intervention strategy that starts with individuals, who come together as a group to act on the community level, which then feeds back to effect positive change at the individual level. Efforts are in process to strengthen measures and package the model for replication/adaptation in other sites.

c. DRUG USER PEER HEALTH ADVOCATES AS MULTILEVEL CHANGE AGENTS

Presenter:

Margaret R. Weeks, Ph.D., Institute for Community Research

Co-Authors:

Jianghong Li, Julia Dickson-Gomez, Maria Martinez, Mark Convey, Kim Radda

Background: Peer-delivered HIV prevention interventions conducted by members of high-risk groups promote change by making use of local settings, social relationships, and indigenous risk avoidance practices, affect multiple levels (personal, network, community), and change the risk environment with the addition of embedded change agents, thereby increasing sustainability.

Methods: The Risk Avoidance Partnership (RAP) project, funded by the National Institute on Drug Abuse, trained drug users in Hartford, CT as Peer Health Advocates (PHAs), to act as social change agents within their networks and neighborhoods, to promote harm reduction in drug-use settings and engage in community advocacy for broad health enhancement. Pre/post risk behavioral, attitudinal, and social network assessments (conducted with PHAs and two of their referred network members at baseline and 6-months) and complementary ethnographic documentation measured project process and outcomes to reduce risk behaviors in trainees and their drug-using contacts, and assess diffusion of intervention effects through drug users' networks in the city.

Findings: Outcome analyses indicated notable role change among PHAs (by their own and peers' assessments), as PHAs became recognized models for prevention practices and community resources for prevention materials. Pre/post risk assessments showed significant reduction in drug risk measures (drugs use rates, needle risk practices) and sex risk measures (number of partners, number of unprotected sexual encounters) among PHAs and similar outcomes among network contacts associated with exposure to RAP interventions, suggesting intervention diffusion and peer feedback support for engaging in risk reduction.

Conclusions: Peer-delivered, diffusion models for health promotion based on empowerment and utilizing inherent social network relationships can have significant positive effects on reduction of health risks over time. However, complexity in delivery, evaluation measurement, and potential for local variation in social network characteristics of high-risk groups present important challenges for implementation in other community contexts.

January 28, 2009
Concurrent Session II
11:30am - 1:00pm

II. COMMUNITY

Room: Balcony B
Facilitator: Christopher Gordon, PhD, NIMH

Individual Presentations:

a. DISSEMINATION OF SCIENCE-BASED PREVENTION BY COMMUNITY COALITIONS

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Abstract:
Preventing adolescent drug use, delinquency, and related problem behaviors is a national priority. Although advances in prevention science over the past two decades have produced a growing list of tested and effective programs and policies for preventing these behaviors, widespread dissemination and high-quality implementation of these effective programs and policies in communities has not been achieved. Community coalitions have been advocated as a mechanism for mobilizing communities to engage in prevention and health promotion efforts because they can bring together diverse community stakeholders to address a shared goal. Activating a coalition of stakeholders could hold promise for coordinated, widespread change in preventive services across organizations and agencies in a community, including the dissemination of tested, effective strategies. This paper presents the results of a study of prevention coalitions participating in a randomized controlled trial of the Communities That Care (CTC) prevention system. Coalitions participating in the intervention are compared to prevention coalitions in the comparison communities to determine whether they implement the CTC system with fidelity, whether this results in the dissemination of prevention science principles to community coalitions, and whether the coalitions participating in the intervention implement more evidence-based prevention programs than prevention coalitions in the control communities. Methods used to assess coalition characteristics and activities and dissemination of science-based prevention principles and programs will be described, and implications for research on dissemination and implementation fidelity of tested, effective prevention programs will be discussed.

b. LEVERAGING LOCAL PARTNERSHIPS TO IMPROVE A NATIONAL SYSTEM OF CARE

Presenter/Primary Contact:

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Authors:

Martha L. Bruce, Ph.D., M.P.H., Weill Cornell Medical College
Thomas H. Sheeran, Ph.D., MS, Weill Cornell Medical College

Can local academic-community partnerships be used to improve quality of care at the national level? We report the process of working in partnership with three local home healthcare agencies to develop a depression intervention that could be disseminated nationally. The project addressed the high prevalence of untreated depression in geriatrichome healthcare patients. The partners worked together to convert 'depression care management' (an evidenced-based intervention developed for primary care) into the practice and organization of home healthcare. Working with three agencies helped the researchers identify factors which were common to home healthcare as a whole vs. factors which were unique to each agency. The common factors were used in adapting the depression care protocol to fit home healthcare generally. The unique factors were used in identifying steps needed to implement the intervention in specific agencies. The investigators then used a process of recruitment and engagement to develop research partnerships with a network of five agencies that were both typical to the home healthcare sector but heterogeneous in terms of geography and organization. The agencies, located in Florida, Oklahoma, Michigan, Vermont and New York City, are now participating in an NIMH-funded, randomized trial (R01) to determine the effectiveness of the intervention (including both the depression care protocol and the implementation procedures) on improving patient care and outcomes. The process of developing the intervention, recruiting the nonlocal partners, and implementing the early steps in the 5-agency trial are used to explicate strategies designed to enhance the development of interventions that can be disseminated effectively.

c. IMPLEMENTATION OF AN EVIDENCE-BASED INTERVENTION BY 72 CBOS OVER TIME

Presenter/Primary Contact:

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The TRIP (Translating Research into Practice) Team, University of California, San Francisco

Background: Although substantial research efforts have gone into scientifically developing and evaluating HIV prevention interventions, very little is known about facilitators and barriers to effective implementation of these programs in practice, or about the characteristics of community-based organization (CBOs) that are associated with implementing evidence-based programs with fidelity to the original research methods.

Methods: We conducted a longitudinal study of an intervention's implementation with 72 CBOs, including semi-structured interviews with 1-5 people from each agency at four time points (baseline, 6, 12, and 24 month follow-up). We conducted 532 interviews with 329 individuals from agencies implementing the intervention. Interview topics included agency and community characteristics, and attitudes about the intervention. We created agency-level scores by calculating means across respondents within each CBO. Agencies self-rated their fidelity to the program's core elements, and we also created externally-rated fidelity scores by having three research team members review all qualitative data that were collected from the interviews and from technical assistance interactions in order to independently rate each agency's overall program fidelity. Qualitative data collected in the interviews and technical assistance interactions were also analyzed.

Findings: Quantitative data analysis was used to examine relationships between predictor variables at baseline and both fidelity scores at the 24-month follow-up. Unsurprisingly, adequate financial and staff resources are significantly related to fidelity, but other agency characteristics also played important roles in successful implementation, including organizational functioning, staff turnover, agency efficacy to implement the intervention, and desire to adhere to guiding principles and core elements. Qualitative data analyses showed that barriers and facilitators of successful program implementation occur at the level of the front line staff, as expected, but also at the level of the organization, the community, and the funders. An ecological approach to understanding and addressing program implementation is needed.

Funding for this study was provided by the National Institute for Mental Health (NIMH)

January 28, 2009
Concurrent Session II
11:30am - 1:00pm

III. TRAINING

Room: Balcony C

Facilitator: Karen Emmons, PhD, Dana-Farber Cancer Institute and Harvard School of Public Health

Individual Presentations:

a. A MODEL OF TRAINING AND TRANSFER OF TRAINING WITH EXAMPLES

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Program effectiveness in community settings cannot surpass skill levels of the people implementing them. Despite repeated acknowledgments that training programs play a key role in the successful transport of programs to real world settings, scant attention has been paid to examining factors involved in training interventionists to deliver evidence-based programs. Both efficacy and effectiveness intervention studies can be conceptualized as having two levels: a) the explicit intervention that includes the theory, content, and implementation procedures described by the program developer, and, b) the implicit intervention that includes the training and technical assistance program that prepares implementers to deliver the explicit intervention as designed, and ensure ongoing implementation quality. A heuristic model of training and transfer of training is presented as a 'road map' for experiments to test hypotheses and systematically investigate the factors that contribute to the apparent breakdown of programs in 'real world' settings and, conversely, how to strengthen dissemination of those programs. The training and transfer of training model helps build a bridge between efficacy research and community implementation. It is based on adult learning, training, and transfer literatures, and includes iterations of practice with expert guidance as a key hypothesized mechanism in the acquisition of competence. The following factors are included: effects of individual interventionist characteristics on learning and subsequent implementation of an intervention; changes in knowledge, attitudes, and skills as outcomes of training; the impact of variations in training design factors (e.g., active learning, video vs. live instruction) on the quality of intervention delivery; the effect of ongoing monitoring; and the setting in which the intervention is deployed. Two community-based preventive interventions will be discussed to illustrate how the model fits 'real world' programs and provides opportunities to test its utility.

b. TRAINING COALITIONS TO ACHIEVE HIGH-QUALITY PROGRAM FIDELITY

Presenter/Primary Contact:

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Funding Agencies:

National Institute on Drug Abuse
National Cancer Institute
National Institute of Child Health and Human Development
National Institute of Mental Health
Center for Substance Abuse Prevention

This presentation describes findings from the Community Youth Development Study, a randomized, five-year evaluation of the efficacy of the Communities That Care (CTC) prevention system in reducing adolescent substance use, delinquency, and other problem behaviors. As part of the CTC system, community coalitions are trained to use local epidemiological data to identify elevated risk factors and depressed protective factors, select effective prevention programs to target these factors, and monitor program implementation to ensure high fidelity.

This presentation examines the degree to which the 12 intervention communities participating in the study used the CTC model to achieve high quality implementation of their selected prevention programs. Across all communities, 16 different prevention programs were implemented, including parent training (group-based and self-administered programs), after-school (skills-based interventions, mentoring, and tutoring services), and school-based programs (drug prevention curricula and school-wide organizational change strategies).

The quality of implementation was assessed using a comprehensive monitoring system that combined local oversight by local CTC prevention coalitions with technical assistance from the University of Washington. The monitoring system included: 1) training for all program staff in programs' theory, content, and delivery methods, and in the importance of implementation fidelity; 2) session checklists and/or surveys completed by staff; 3) observations of program sessions conducted by implementers' supervisors, CTC coalition members, or other volunteers; 4) collection of attendance records; and 5) administration of pre- and post-surveys to measure desired changes in program participants.

Based on observer reports and self-reports from program implementers, high levels of fidelity were achieved. The majority of required material, core components, and lessons were delivered; implementers were prepared, enthusiastic, and knowledgeable; participation was high. The findings indicate that by using a comprehensive system to proactively monitor implementation, community coalitions can ensure high quality replication of effective prevention programs.

c. STAFF NETWORKS AS A SOURCE OF SKILL TRANSFER TO SUPPORT DISSEMINATION

Presenter/Primary Contact:

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Introduction: A significant challenge in program dissemination is a lack of skills among staff charged with implementing evidence-based programs. Training programs are often expensive, time consuming, and inaccessible, particularly in non-profit organizations. We examined whether or not staff networks can serve as vehicles for skills transfer using an afterschool childcare program in a non-profit organization as a case study.

Methods: Twenty sites of the YMCA of Greater Boston were implementing changes in afterschool programs to support children's health. We surveyed 80 of 91 staff members to study the skill-sharing patterns in their network of colleagues, followed by a cross-sectional, sociometric network analysis. Our descriptive measure of interest was Network Density, a measure of system-level connectedness. At the staff-level, the dependent variable was Skill Gains, the number of key implementation skills gained from the network. The independent variable was Out-Degree, the number of individuals to whom respondents noted a program-related connection. We utilized a multiple linear regression model to estimate the relationship between Out-Degree and Skill Gains and adjusted for clustering of staff in sites.

Results: We achieved a response rate of 88%. Most staff (77%) reported gaining at least one skill from the network, but only two percent of potential network connections were established. The regression model showed that Out-Degree (number of program-related contacts) was significantly associated with Skill Gains (_ = 0.49, $p<0.0001$), independent of other variables.

Conclusion: Informal skill transfer in staff networks may be a useful complement to formal training for implementation of health promotion programs, but was underutilized in this network. Future research employing longitudinal and/or multi-site data should examine these findings in greater detail. Experimentation in practice may also lead to novel ways of supplementing formal training efforts for wide dissemination of effective programs.

Additional Information: Funding support for the lead author (S.R.) was provided through the National Cancer Institute by the Harvard School of Public Health Education Program in Cancer Prevention Control (5 R25 CA057711-14) and also through the Dana Farber/Harvard Cancer Center via the last author (K.V.). Two authors (J.W. and S.G.) were supported by a gift from the Pritzker Traubert Foundations to the Harvard School of Public Health.

January 28, 2009
Concurrent Session II
11:30am - 1:00pm

IV. CONCEPTUAL MODELS FOR IMPLEMENTATION RESEARCH

Room: Main Auditorium
Session: Panel

Chair/Contact:

Enola Proctor, PhD
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Discussant:

John Landsverk, PhD, Children's Hospital in San Diego

Panelists:

Kimberly Eaton Hoagwood, PhD, Columbia University
Brian Mittman, PhD, VA Greater Los Angeles Healthcare System

Introduction and purpose of panel: The gap between care that is known to be effective and care that is delivered reflects, in large measure, a paucity of evidence about implementation. Most information about implementation processes relies on anecdotal evidence, case studies, or highly controlled experiments that have limited external validity and yield few practical implications. A true science of implementation is just emerging. Papers at the 2007 Dissemination and Implementation conference stressed the need for conceptual models and theoretical development and called for the development of a broad theory and fewer smaller theories to guide this emerging field. The absence of an overarching theory reflects the wide array of phenomena influencing implementation, and the consequent need to bring multiple perspectives and methods to bear upon its study. Implementation research (IR) requires conceptual models to intellectually coalesce and shape this emerging field – models with consistent language, clearly defined constructs, measures for these constructs, and an analytical model hypothesizing links between measured constructs.

Methods: This panel advances the development of conceptual models for implementation research by presenting conceptual models that currently guide the work of research centers focused on this agenda. Each paper will briefly overview its research agenda in implementation science, then present the overarching conceptual model that guides its research. Papers will identify the theoretical bases, key concepts, and relationships between concepts that are being empirically tested. Half the session will be reserved for questions, critique of the models, and a consolidation of similarities across conceptual models. The presenters will then derive implications for advancing theory in implementation science, which will be fed back to Conference organizers.

Individual Presentations:

a. CONCEPTUALIZING IMPLEMENTATION RESEARCH IN PUBLIC SOCIAL SERVICES

Co-authors:

Enola Proctor, PhD, Washington University in St. Louis
John Landsverk, PhD, Washington University in St. Louis, Children's Hospital in San Diego

Objective: The CMHSR conducts research on the implementation of evidence-based mental health treatments in public social service settings, where vulnerable populations rely for mental health care. Relative to hospital based medicine, these settings lag in quality of care research. Yet their unique potential to extend evidence-based care to vulnerable populations makes implementation research (IR) a high priority.

Methods: Center research is guided by a heuristic conceptual model highlighting major distinctions between change strategies and outcomes, measurement at multiple levels, and the perspective of multiple stakeholders. The model draws from (1) the NCI's "stage pipeline" model; (2) Shortell's multi-level model of "change for performance improvement," and (3) health services conceptual models that distinguish structure, process, and outcomes. CMHSR's model posits nested levels and distinguishes key implementation processes and outcomes. Two "core technologies" are distinguished: evidence-based intervention strategies and separate implementation strategies. Three distinct but interrelated types of outcomes-- implementation, service, and client outcomes—are geared to constructs from the IOM quality report. While consumer outcomes are the ultimate criteria, IR requires outcomes that are conceptually and empirically distinct from those of service and treatment effectiveness, implementation outcomes required distinct measurement.

Findings: The model informs Center research projects, guides measurement and analysis, and shapes its research-support cores. An Implementation Outcomes Unit guides researchers' conceptualization and mixed-methods measurement of such implementation outcomes as an intervention's penetration within a target organization, its acceptability to and adoption by stakeholders, the feasibility of its use, and its sustainability over time. The extent to which the IOM standards of care are advanced by successful implementation of effective treatments awaits empirical test. And yet to be discovered is the sufficiency of one comprehensive implementation model or the need for different models reflecting specific clinical conditions, treatment types, or service delivery settings.

Funding: National Institute of Mental Health

b. MULTI-LEVEL MODELS OF IMPLEMENTATION IN THE DEPARTMENT OF VETERANS AFFAIRS

Author:

Brian S. Mittman, PhD, VA Greater Los Angeles Healthcare System

Objective: The U.S. Department of Veterans Affairs Quality Enhancement Research Initiative (QUERI) conducts a large program of implementation research addressing diverse research, policy and practice improvement goals. The VA Center for Implementation Research and Improvement Science (CIRIS) supports this work through a portfolio of theory- and methods development projects as well as technical assistance and consultation to research and policy/practice stakeholders. QUERI and CIRIS implementation research activity is guided by an over-arching conceptual model based on the multi-level hypothesis of clinical practice change, augmented by a series of individual conceptual models

capturing the role of a broad range of factors influencing implementation processes and outcomes. This presentation will describe the over-arching model and selected examples of individual models.

Methods: The multi-level framework builds on theories of organization and management as well as the sociology of the professions, and suggests that change in clinical practice requires coordinated efforts at multiple levels of the healthcare delivery. QUERI studies examining implementation processes and evaluating strategies to facilitate implementation are guided by individual frameworks such as PARIHS and diffusion of innovations, which hypothesize specific influences on practice change processes and outcomes, such as characteristics of the evidence or innovation to be implemented, features of the implementation facilitation process and characteristics of the professionals and organizational units targeted.

Findings: QUERI implementation studies are developing insights into the detailed processes and mechanisms of change that occur during implementation of evidence-based practice, the contextual factors that affect these processes and the manner in which the relationship between these variables and change outcomes varies across different types of clinical care and targeted care processes.

Funding: QUERI and CIRIS are funded by the U.S. Department of Veterans Affairs, with additional funding from other public and private research funding agencies.

c. PRACTICAL IMPLEMENTATION RESEARCH WITHIN A STATE POLICY ENVIRONMENT

Co-Authors:

Kimberly Hoagwood, PhD, New York State Office of Mental Health and Columbia University
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Barbara J. Burns, PhD, Duke University
Charles Glisson, PhD, University of Tennessee
James Jaccard, PhD, Florida International University

Objective: Improving the public mental health delivery system for children and families requires *dissemination* of new clinical services and *activation* of individual (clinicians, supervisors, families, youth), organizational (agency-level), and policy (fiscal, regulatory) changes. Our Developing Center in Children's Mental Health, structurally configured within the New York State Office of Mental Health, provides an unusual opportunity to examine a range of implementation strategies for disseminating new clinical practices for children and families within a large and complex public mental health system.

Methods: Our conceptual framework rests on three theoretical pillars: the unified theory of behavior change (Jaccard) drawn from basic behavioral sciences to understand the triggers for behavior change within individuals (clinicians, supervisors, families, youth); social organizational theory (Glisson) to understand the organizational processes (culture, climate, structure) that affect agency adoption of new practices; and participatory action research based on Habermas' theory of communicative action,

to ration and share decision-making about research activities among diverse constituents. In our Center we seek to integrate these explanatory constructs from vastly different literatures to assure greater practical utility of the findings for stakeholders. These include New York State and City cabinet policy-makers; treatment developers whose empirically-based interventions are being disseminated throughout New York and other states; family advocates and advisors within national, state and city organizations; and academic researchers.

Findings: We are developing and testing specific contextual strategies targeting consumers (families and youth) and organizational domains (e.g., measurement feedback systems) to improve the adoption and sustainability of a set of specific empirically-based clinical practices (screening, assessments, outreach strategies, and treatments). Basing this Center directly within the OMH policy environment enables findings from our studies to be implemented rapidly.

Funding: NIMH, New York State Office of Mental Health, Columbia University

January 28, 2009
Concurrent Session II
11:30am - 1:00pm

V. DEFINING TREATMENT INTEGRITY: ADHERENCE AND COMPETENCE IN PRACTICE

Room: C1/C2
Session: Think Tank

Chair/Discussant/Primary Contact:
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Discussant:
Ken Weingardt, PhD, Stanford University School of Medicine

Presenters:
John Baer, PhD, University of Washington
Nancy Roget, MA, University of Nevada, Reno
Craig Rosen, PhD, Stanford University School of Medicine

Treatment integrity or fidelity, defined as clinician adherence and competence, is a check on the independent variable used to identify whether treatments are delivered as intended in randomized controlled trials. This "Think Tank" session will explore whether traditional definitions of adherence and competence are adequate for use in substance use disorder (SUD) treatment practice settings, and appropriate for the purposes of implementation science. For example, should evaluations of practitioner competence be based on linear implementation of a treatment manual? Can a treatment be delivered with high fidelity if the practitioner is allowed to select which treatment components to apply and when? Are there core principles or components of empirically based SUD treatments that should guide flexible treatment adaptation? Could competence be based on skillfully applying evidence-based practices in order to achieve the specific common proximal outcomes that research has linked to positive long-term outcomes? How might an implementation focused definition of treatment fidelity be measured? The panel includes both research and practice-oriented empirically based treatment implementation experts. Panel participants will (a) present a case study that involves the use of a web-based course to provide outpatient mental health counselors with training in Motivational Interviewing (b) provide an overview of the empirical literature regarding fidelity measures for this evidence-based practice, and (c) engage the group in a discussion of how different perspectives on fidelity can lead to different research questions, different research design and methodological considerations, and ultimately different metrics of successful implementation. A graphic recorder will listen, synthesize and transcribe information that is generated in the Think Tank group into a visual, attractive graphical form that reflects the importance, priority, and relevance of the information to the Think Tank objectives.

January 28, 2009
Concurrent Session II
11:30am - 1:00pm

VI. EMPLOYING BEHAVIORAL AND SOCIAL SCIENCE TO MEET CHALLENGES IN HEALTH CARE QUALITY IMPROVEMENT

Room: F1/F2
Session: Think Tank

Chair/Primary Contact:

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Discussant:

Lawrence Fine, MD, DrPH, NHLBI[1]

Presenter:

P. Jonathan White, MD, USDHHS Agency for Healthcare Research and Quality

As knowledge of persistent problems with the quality, safety and efficiency of healthcare (e.g., medical errors, gaps in delivery of clinical preventive and treatment services, duplicative services) has become more widely known,[2] federal agencies[3] and private foundations[4] have increasingly supported implementation research designed to understand how to engender improvements. Recently, research has focused on implementing health information technologies (HIT) to facilitate improvement. HIT interventions include computerized prescription order entry systems to reduce medication errors in hospitals, electronic health records and computerized decision support systems to improve patient care in primary care settings, healthcare information exchange across multiple healthcare institutions within states and regions, and efforts to link public health functions to mainstream health care providers. Research to date has revealed how, in order to be successful, HIT-facilitated healthcare quality, safety, and efficiency improvement interventions (QSEIs) require attention to organizational context, provider and system behavior, and processes of change. There is a clear need to engage additional behavioral and social science (BSS) expertise for HIT-facilitated QSEIs to become more effective.

The purpose of this session is to stimulate a productive exchange of ideas for improving the "causal generalizable validity"[5] of HIT-facilitated QSEIs. In addition, we hope to build cross-agency collaborations and grow the network of BSS researchers working on healthcare QSEI.

Following a brief overview of new QSI funding opportunities at AHRQ,[6] the session will present a specific case study of HIT-facilitated QSEI implementation research drawn from efforts funded under AHRQ's Transforming Healthcare Quality through Information Technology (THQIT) funding initiative. THQIT projects implemented and evaluated HIT-facilitated QSIs in small rural and large hospital systems, community health centers, and in radiology services, among other settings. Participants will be challenged to offer constructive suggestions for using BSS theories, measures, and research methods to enhance future initiatives.

[1] Invited: Lawrence Fine, MD, NHLBI.
[2] See National Healthcare Quality and Disparities Reports, 2003-2007 at www.ahrq.gov
[3] For example, NHLBI supported randomized controlled trials of guideline implementation interventions for asthma and other conditions (e.g., M Cabana, various publications). AHRQ has supported similar efforts in asthma care and other conditions.
[4] For example, ICICE –Improving Chronic Illness Care Evaluation focused on implementation of the Chronic Care Model.
[5] Shadish, Cook, Campbell, 2004.
[6] WWW.AHRQ.GOV

January 28, 2009
Concurrent Session II
11:30am - 1:00pm

VII. PLANNING FOR ADOPTION OF CLINICAL CARE PRACTICES IN GLOBAL HEALTH

Room: G1/G2
Session: Think Tank

Chair: José Belizán, MD, PhD, Institute for Clinical Effectiveness and Health Policy (IECS), Buenos Aires, Argentina

Primary Contact:

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Facilitator: Marci Campbell, PhD, MPH, RD, University of North Carolina at Chapel Hill

Discussant: Emily Rugel, MPH, Fogarty International Center, NIH

Presenters:

James Dearing, PhD, MA, Kaiser Permanente of Colorado
Linda Kupfer, PhD, Fogarty International Center, NIH
Madeleine Wallace, PhD, Division of Program Coordination, Planning, and Strategic Initiatives, NIH

This Think Tank will stimulate discussion about methods of planning for widespread adoption from the inception of a research effort. The case study being utilized appeared in the May 2008 issue of the New England Journal of Medicine, and co-authors José Belizán and Marci Campbell will provide first-hand insight into their methodology, particularly the use of formative research. Jim Dearing will provide an overview of diffusion theory and discuss operationalizing translational strategies, and Madeleine Wallace will present a draft model for the adoption and successful implementation of evidence-based interventions.

The original research effort involved 19 hospitals in Argentina and Uruguay that were randomized to serve as intervention and control sites for a multi-faceted behavioral intervention on the use of episiotomy and evidence-based management of the third stage of labor. Unique aspects of the research design included extensive qualitative data collection and analysis during the planning stages, training for peer-identified opinion leaders, and academic detailing to participating institutions. Overall, the intervention had a sustained effect on changing the behavior of birth attendants, increasing appropriate use of prophylactic oxytocin, decreasing episiotomy rates, and reducing postpartum hemorrhage.

The presentation has three principal goals, and participants will take part in small-group discussions aligned with each of these. The first goal is refining a novel late-stage translational social influence model designed to increase the likelihood of adoption and successful implementation of evidence-based interventions. The second component is a discussion of a planned effort to translate this proven clinical practice to a new setting in Ghana, and the final aim is soliciting input about the implications of this type of research for the fields of obstetrics and international development.

A list of final, written recommendations arising from these facilitated discussions will be shared with the Program Committee and may also inform future research efforts and publications.

January 28, 2009
Concurrent Session III
2:00pm - 3:30pm

I. DISSEMINATION OF AN EFFECTIVE SKIN CANCER PREVENTION PROGRAM

Room: Balcony A

Chair/Primary Contact:

Karen Glanz, PhD, MPH
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Session: Panel

Panelists:

Cam Escoffery, PhD, MPH, Emory University
Borsika A. Rabin, MPH, Saint Louis University School of Public Health

Acknowledgement: This research was funded by the National Cancer Institute (NCI Grant # CA 92505).

Summary: Skin cancer is commonly diagnosed in the United States but is preventable. The Pool Cool skin cancer prevention program is a multi-component educational and environmental intervention that has shown significant positive effects on children's sun protection behaviors and on sun-safety environments at swimming pools. From 2003 to 2006, the Pool Cool diffusion trial evaluated the effects of two strategies for program diffusion on: 1) program implementation, maintenance, and sustainability; 2) sun-safe policies and environments; and 3) sun protection habits and sunburns among children. Ancillary aims included examining organizational predictors of diffusion and the mediating role of lifeguards and aquatic staff. The study used a three-level nested experimental design with over 400 pools across the United States. Pools were assigned to Field Coordinators by region. Regions were randomized to either Basic or Enhanced (reinforcement plus feedback) diffusion conditions. Survey data were collected from pool managers, lifeguards and parents (for themselves and their 5 to 10 year old children) at the beginning and end of each summer. An independent process evaluation was conducted each year, including site visits and telephone interviews with key informants at a sample of 120 participating pools. Process evaluation data provided information about program implementation, pool environments and staff sun-safety practices.

The first presentation on this panel will discuss the effects of two strategies for diffusion of the Pool Cool skin cancer prevention program on program implementation, maintenance, and sustainability and sun-safe policies and environments. The second presentation will report on data from the process evaluation to describe program implementation in greater detail. The third presentation will report on an analysis of the mediating role of lifeguards' implementation of Pool Cool on parents' exposure to the program and children's sun protection practices.

Individual Presentations:

a. COMPARISON OF TWO DISSEMINATION STRATEGIES FOR IMPLEMENTATION AND MAINTENANCE

Co-Authors:
Karen Glanza, PhD, MPH, Eric Nehl, MS, and Dawn Hall, MPH, Emory University

The primary aim of the Pool Cool diffusion trial was to compare the effects of two strategies for diffusion (Basic and Enhanced) on: 1) program implementation, maintenance, and sustainability and 2) sun-safe policies and environments.

Pool managers completed surveys at the beginning and end of each summer. Surveys asked about program implementation, sun-safe policies and environments, obstacles and supporting factors, and demographics. In 2005 and 2006, follow-up surveys also evaluated the sustainability of Pool Cool. Group differences (Basic versus Enhanced) in program implementation, maintenance, and sustainability and sun-safe policies and environments were analyzed using MANCOVAs. Multi-level analyses accounted for clustering by region. Organizational predictors were identified using regression techniques. The sample included 389 pools from across the US with at least one baseline and one follow-up survey.

Increases in implementation from first to second follow-up were greater in the Enhanced group [F=4.11, p=.04]. From first to last follow-up, implementation increased within the Enhanced group only [F=7.13, p=.008], indicating higher program maintenance. Increases in sun-safe policies and environments from baseline to last follow-up were greater within the Enhanced group [F=8.88, p=.003]. In 2006, sustainability scores were marginally higher among Enhanced pools [F=3.10, p=.08]. Sun-safe policies and environments increased across both groups with each year of participation, but there was a greater increase in policies and environments from baseline to last follow-up in the Enhanced group [F=8.88, p=.003]. The perceived importance of supporting factors and pool attendance size were found to be significant predictors of program implementation and sun-safe policies and environments.

Over time, Enhanced group pools had higher levels of program implementation, maintenance and sustainability and greater increases in sun-safe policies and environments. These results show that participant reinforcements and feedback can improve long-term dissemination efforts.

b. PROCESS EVALUATION OF POOL COOL PROGRAM IMPLEMENTATION

Co-Authors:
Cam Escofferya, PhD, MPH, Emory University
Dawn Hall, MPH, Emory University
Eric Nehl, MS, Emory University
Karen Glanz, PhD, MPH, Emory University

Objectives of the process evaluation of the Pool Cool program included assessing use of program components across Basic and Enhanced group pools, the extent of program implementation, and programmatic factors that contribute to successful program diffusion.

Each year of the Pool Cool diffusion trial, 80 telephone interviews and 40 site visits were completed at participating pools across the United States. Pool contacts were interviewed about program participation, implementation and use of program components, and facilitators and barriers to

implementation. During site visits, evaluators made observations of program implementation, the pool environment, and sun-safety practices of aquatic staff. Primary and supplementary implementation scores were developed and calculated for each pool, based upon responses to interview items. Descriptive statistics were computed for major implementation items, and chi-squares and t-tests were used to assess differences in implementation between Basic and Enhanced group pools. Open-ended responses were coded into major themes.

Primary implementation scores ranged from 68.3% to 73.2%, and supplementary implementation scores ranged from 30.7% to 36.9% across the four years of the study. There were few differences in implementation between Basic and Enhanced group pools, but Enhanced group pools reported using the poolside activity "Sun Jeopardy" significantly more than Basic group pools (56.7% vs. 23.3%; $p < .0001$). Factors that facilitated program implementation included receipt of program materials, simplicity of the lessons, knowledge gained about skin cancer, appeal of materials to young children and ease of program implementation. Time constraints were the main barrier to implementation.

These results indicate consistently high levels of program implementation across both Basic and Enhanced group pools. Process evaluation data provides detailed information about program implementation within the multi-year Pool Cool diffusion trial.

c. DISSEMINATION OF THE POOL COOL PROGRAM THROUGH LIFEGUARDS

Co-Authors:

Borsika A. Rabin, MPH, Mpharm, Saint Louis University
Eric Nehl, MS, Emory University
Tom Elliott, MPH, Emory University
Anjali D. Deshpande, PhD, MPH, Washington University
Ross C. Brownson, PhD, Washington University
Karen Glanz, PhD, MPH, Emory University

Pool Cool is a widely disseminated skin cancer prevention program. Lifeguards play a potential mediating role in the implementation of the program. The purpose of this analysis was to assess how lifeguard implementation of Pool Cool influences parents' exposure to Pool Cool and children's sun protection practices.

Multilevel analyses were conducted using lifeguard and parent/child survey data from 2004 and 2005. Lifeguard implementation of Pool Cool, was measured using a composite score that assessed whether lifeguards implemented certain components of the program. Parent exposure to the program was evaluated using a composite score that measured whether the parent received certain Pool Cool items and reported that swimming lessons were taught at his/her pool. Children's sun protection practices included sun protection habits, sun exposure, and sunburns. Other variables included were participant background characteristics, sun-safety environments and policies, sun protection attitudes and behaviors, pool characteristics, and enhanced versus basic treatment group. In order to assess the robustness of our findings across years, the final 2004 models developed for each dependent variable were replicated using data from 2005.

In 2004, data collected from 2785 parents/children, 2430 lifeguards, and 243 pools were included in the analysis. In 2005, data collected from 3072 parents/children, 2649 lifeguards, and 253 pools were

analyzed. Two separate models were developed for the dependent variables. Coefficient estimates for lifeguard implementation and other variables included in the final models will be presented. Findings from 2004 and 2005 will be compared.

This analysis describes the role of lifeguard implementation of Pool Cool in parental exposure to an effective skin cancer prevention intervention and in improving children's sun protection practices.

January 28, 2009
Concurrent Session III
2:00pm - 3:30pm

II. NEW TOOLS FOR DISSEMINATION AND IMPLEMENTATION

Room: Balcony B
Facilitator: Thomas F. Hilton, PhD, NIDA

Individual Presentations

a. DISTANCE TECHNOLOGIES TO DISSEMINATE HIV PREVENTION PROGRAMS

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Funding: NIMH (R01-MH079730 and P30-MH52776)

Research has identified a number of efficacious HIV prevention behavioral interventions relevant to the needs of frontline AIDS service organizations. However, nongovernmental organizations (NGOs) that carry out community programs in world regions hardest-hit by AIDS are far-removed from sources of training in evidence-based interventions. This presentation will highlight findings from over 10 years of our NIMH-supported research rigorously evaluating the effects of approaches for disseminating HIV prevention interventions from the research arena to NGOs. Across studies, elements critical to successful NGO adoption of new program models have been: (1) sufficient NGO capacity and motivation to offer the new intervention; (2) intensive NGO staff training in intervention methods; (3) ongoing access by NGOs to post-training consultation with someone familiar with both the intervention model and with NGO service delivery issues; and (4) encouragement of NGO tailoring, cultural adaptation, and "ownership" of the new program.

Advanced communication technologiesæincluding Internet, web-based, and DVD-based approachesæhave the potential to bring training in new evidence-based HIV prevention interventions to the staffs of AIDS NGOs, even in low-and middle-income countries. This presentation will describe how traditional face-to-face workshop methods for training NGO staff to implement new interventions were adapted for Internet- and computer-based distance training modalities in our studies. These methods include our production of interactive web-based distance curricula modules used to train NGO staff in the intervention model being disseminated. The electronic curricula incorporated streaming audio and video tools, video modeling of key intervention techniques, and assistance to NGOs in planning, tailoring, and problem-solving the implementation of the new intervention. Ongoing distance consultation accompanied and followed NGO staff use of the distance training curricula, and provided individualized problem-solving concerning NGO plans to implement the intervention in their own communities.

A randomized trial was conducted to compare this distance training dissemination model with the more traditional approach of distributing intervention manuals to NGOs. Carried out with 86 AIDS NGOs in 78 countries in Africa, Eastern Europe, Latin America, and the Caribbean regions, the trial found that the distance training approach resulted in more frequent NGO adoption and use of the disseminated intervention in their communities at 12-month follow-up (43% adoption by distance trained NGOs, 17% by controls), greater fidelity to the evidence-based model, and high levels of NGO staff satisfaction with distance training. Current studies are now comparing the effectiveness and the cost-effectiveness of face-to-face staff NGO training methods with comparable staff training offered using the Internet.

b. REGISTRY OF PUBLIC HEALTH KNOWLEDGE TRANSLATION METHODS AND TOOLS

Presenter/Primary Contact:

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Maureen Dobbins, RN, PhD, Associate Professor[1,2]
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The National Collaborating Centre for Methods and Tools (NCCMT) was officially launched in May 2007 as part of the Government of Canada's commitment to renew and strengthen public health across the country. The mandate of the NCCMT is to improve access to and use of evidence-informed knowledge translation methods and tools for public health policy-making, program decision-making, practice and research in Canada.

This presentation will discuss an innovative Canadian model and web-based technology to facilitate uptake of critically appraised knowledge translation methods and tools by public health stakeholders in various roles. The NCCMT's "Registry for Knowledge Translation" incorporates an evidence-based model with a comprehensive search strategy, processes for inclusion screening, quality appraisal and data extraction. The final product is a two-page summary of the public health knowledge translation method or tool that is posted on the Registry website. This model provides a filtered approach to provide stakeholders with current, innovative summaries of key methods and tools to carry out core public health functions related to knowledge translation. The "Registry for Knowledge Translation" is a unique technology comprising an online searchable database with an interactive, moderated discussion board where members can discuss issues, questions, gaps, needs and experiences related to methods and tools for knowledge translation.

This presentation will discuss the 'lessons learned' from the development and implementation of this national dissemination model and web-based technology. Audience members will learn the key features of this technology, how to search and find quality appraised knowledge translation methods and tools, and how to become involved in the web-based discussion board.

c. A TOOL FOR DEVELOPING RESEARCH KNOWLEDGE TRANSLATION PLANS

Presenter/Primary Contact:

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Study Funders: Canadian Health Services Research Foundation; Canadian Institutes of Health Research; UK National Health Services Delivery and Organization Research and Development Program; the Netherlands Organization for Health Research and Development

Agencies that fund health research are placing increased emphasis on their responsibilities for ensuring that the research they fund results in the creation and application of beneficial knowledge. As part of this trend, research funders are increasingly expecting applications to include research knowledge translation (KT) plans in their research grant submissions; that is for research applications to include research-related activities aimed particularly at maximizing the relevance and impact of the research.

Because this expectation for a translation component to research is relatively new, little is known about how best to develop and evaluate these KT plans. Moreover, health research funding agencies are each introducing a variety of tools and strategies for promoting research translation activities within individual research studies, but this has preceded any systematic development of criteria or assessment of impact. The goal of this study was to develop a tool to support the knowledge translation components of the research grant application and funding process, and to gather input from the researcher and reviewer community on its potential utility.

We developed a tool (study KT guide) applicable to a wide range of research. The guide assumes that KT activities need to be considered across the full research continuum and may include many possible goals, participants, and methods. The study guide provides a conceptual framework for guiding researchers and reviewers in considering the most appropriate KT plan according to the particular research context.

Health services researchers asked to consider the guide in relation to one of their recent grant proposals or grant reviews were highly positive. Study funders are now adapting the guide for use in the research application process. This presentation will provide an overview of the study KT guide and its conceptual underpinnings.

January 28, 2009
Concurrent Session III
2:00pm - 3:30pm

III. PROCESS OF DISSEMINATING INTERVENTIONS

Room: Balcony C
Facilitator: Rachel J. Mandal, MSc, OBSSR

Individual Presentations:

a. INFLUENCING EMPLOYER BENEFIT PURCHASING BEHAVIOR

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RCTs demonstrate that depression management can improve clinical and organizational outcomes sufficiently for selected employers to realize a return on investment for purchasing evidence-based care. Rather than usual care marketing which uses voltage-enhanced promises to sell voltage-diminished products, this study uses an experimental design to test an evidence-based (EB) marketing intervention to encourage employers to purchase a depression management product that offers the type, intensity and duration of care shown to provide clinical and organizational value in 400 employer members of 20 business coalitions. In addition to testing intervention effect on purchasing, the investigation will apply an innovative conceptual framework derived from social network theory and dissemination research to identify: (1) mediators and organization-level moderators of intervention impact on employer benefit purchasing behavior. Results of this study will inform debate on one of the most pivotal problems in the translation of evidence-based care to 'real world' settings: whether purchasers can be influenced to buy health care products on the basis of value rather than cost. If EB marketing is superior, the study will provide support for an evidence-based approach to market new health care products to employers on the basis of the product's clinical and organizational value. Usual care marketing efforts may achieve comparable outcomes to EB if the limiting factors in benefit purchasing are organizational constraints that no intervention can meaningfully modify. Support for this scenario encourages the marketing of new products to targeted employers with empirically identified organizational vendor characteristics.

b. ETHNOGRAPHIC DISSEMINATION IN STUDY COMMUNITIES IN MUMBAI, INDIA

Presenter/Primary Contact:

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Niranjan Saggurti. PhD, Population Council

Introduction: The discussion of dissemination most frequently refers to the distribution of research and intervention results to policy makers and program developers for "going to scale." Less well discussed is how results are conveyed back to the study populations themselves for purposes of post-project sustainability and generation of new community-based initiatives. This paper will describe a yearlong effort (2007-08) to disseminate the results of a five-year, NIH-funded (2001-2006) project focused on the reduction of sexual risk and HIV/STI transmission among married men living in urban poor communities in Mumbai, India. The term "ethnographic" indicates the utilization of community data to structure the dissemination process.

Research Methods: The project was an Indo-US collaboration that was implemented in three communities with a total population of 700,000. The first phase of the project involved one year of formative ethnographic research that included a community baseline survey. The second phase (three years) involved multi-level intervention, consisting of community education; training and support for health providers; and involvement of their male patients seeking care for culturally-based sexual health problems. The third phase involved evaluation of the impact of the intervention on the communities, on providers and on patients. The data in the formative phase, the description of the intervention and the outcome results formed the basis for a series of 21 dissemination meetings in the three communities.

Results: Dissemination resulted in increased support for maintaining the RISHTA project in the communities, development of community action groups to take on the responsibility for education on risk reduction and initiation of a new series of community-based activities and the identification of new leadership for community education. These developments increased the ability of community residents to advocate for resources from municipal, state and national policy makers, which further contributed to sustainability.

This project was funded by the National Institute for Mental Health (RO1-MH64875)

c. PARTNERSHIP RESEARCH: A PRACTICAL DESIGN FOR EVALUATION OF A NATURAL EXPERIMENT

Presenter/Primary Contact:

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Introduction: Real examples of practical trial designs that include evaluation of implementation methods are badly needed if we are to advance implementation knowledge from the many natural experiments going on in health care today. The objective of this presentation is to describe such an example and to highlight the research challenges being addressed in this in-progress study. The DIAMOND Study (funded by NIMH) is evaluating a statewide initiative in Minnesota to change payment and care systems for primary care of all adults with depression.

Methods: The key design and methods featured in this study are:

1. Partnership between researchers and implementation leaders from the beginning of the change idea through development and implementation of the study proposal and initiative
2. Staggered implementation, multiple baseline design that addresses both research rigor and implementation feasibility
3. Identification and repeated surveys of depressed subjects receiving care over three years in the 93 involved clinics from data aggregated from weekly claims data from seven different payers (without intruding on clinic care operations)
4. Use of claims data from those same payers to analyze utilization and health care cost impact of the change in depression care
5. Aggregation of data from payers, clinics, and the training system to document costs of the change initiative for all participants
6. Pre-post surveys of clinic leaders to test an implantation conceptual framework of the importance of priority, change readiness, and practice systems for patient outcomes

Findings: At this 7-8 month point, there have been both challenges and successes. The challenges of developing a smooth system to coordinate and use plan data to identify subjects in a timely way have been great, the partnership has worked exceedingly well, and we have 99.5% response rate from clinic surveys. These innovative methods are working well and deserve to be widely known.

January 28, 2009
Concurrent Session III
2:00pm - 3:30pm

IV. LINKING PREVENTION SCIENCE AND COMMUNITY ENGAGEMENT IN CHILD WELFARE

Room: Main Auditorium
Session: Panel

Chair/Primary Contact:

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Panelists:

Dr. Nick Axford, Dartington Social Research Unit, UK
Brian Bumbarger, Penn State University
Dr. Michael Little, Dartington Social Research Unit, UK

Overall purpose: How can high quality prevention science influence policy and practice in children's services? As Nutely (2007) so eloquently states, "Empirical studies have shown, however, that research use is rarely a straight forward process of simple application to policy and practice decision making. More often the use of research is a subtle and complex process, difficult to trace and resulting in equally subtle and complex outcomes" (Nutley, Walter, & Davies, 2007, p.33). The following panel presentation will utilize three recent projects designed to address the question above and to illustrate the complexity iterative process that was experienced. Specifically, the presentations will focusing on: (a) what was done; (b) how successful it was at shaping policy and practice; and (c) what lessons may be drawn for others undertaking similar ventures and for theory in the area of Type 2 Translation Research. Three papers consider respectively:

1. A large-scale dissemination effort involving over 140 evidence-based programme replications in one state in the US
2. The use of an operating system to encourage the development of evidence-based services in several sites in Ireland
3. The adaptation of a proven model from the US for a different context with a view to it being evaluated by RCT and then integrated into the mainstream if found to achieve the intended impact on outcomes.

The key findings are:

1. Key proactive technical assistance strategies are needed and must remain ongoing
2. Goodness of fit between needs and programming is examined closely
3. A plan for systematic and sanctioned adaptation that is implemented
4. Partnership across disciplines is critical for attention to various issues in going to scale.
5. Social influence approach exists whether one chooses to engage in it or not.
6. The skills required for this field of "implementation science" (Woolf, 2008) are application of multiple methods in terms of design, communication, and empowerment.

Individual Presentations:

a. AFTER RANDOMIZED TRIALS: ISSUES RELATED TO DISSEMINATION OF EVIDENCE-BASED INTERVENTIONS

Presenter: Brian Bumbarger, Penn State University

Demonstrating the efficacy and effectiveness of prevention programmes in rigorous randomized trials is only the beginning of a process that may lead to better public health outcomes. Although a growing number of programmes have been shown to be effective at reducing drug use and delinquency among young people under carefully controlled conditions, we are now faced with a new set of obstacles. First, these evidence-based programmes are still underutilized compared to prevention strategies with no empirical support. Second, when effective programmes are used the evidence suggests they are not being implemented with quality and fidelity. Third, effective programmes are often initiated with short-term grant funding, creating a challenge for sustainability beyond seed funding. We discuss each of these challenges, and present lessons learned from a large-scale dissemination effort involving over 140 evidence-based programme replications in one state in the US.

Overall we found that:
Policy makers must recognise the importance of balancing the greater promotion of evidence-based interventions (EBIs) with the need to:

- improve the readiness of schools and community agencies to adopt EBIs through special government initiatives;
- support communities and schools in their implementation of EBIs through targeted training and ongoing support to promote high quality and sustainability.

Practitioners face the following challenges when implementing evidence-based interventions:

- assessing the stability of the implementing agency's infrastructure and the skills and support of both administrators and implementers;
- creating a detailed plan for the implementation of these interventions with high fidelity and quality;
- adopting specific quality-monitoring processes to ensure that the programme is being implemented the way it is supposed to be;

Effective programme adoption and implementation requires initial training that is interactive and engaging, provides opportunities for behavioral rehearsal, *and is followed up with ongoing coaching, technical assistance and support.*

b. LINKING PREVENTION SCIENCE AND COMMUNITY ENGAGEMENT: A CASE STUDY OF THE IRELAND DISADVANTAGED CHILDREN AND YOUTH PROGRAMME

Presenter: Dr. Michael Little, Dartington Social Research Unit, UK

Randomized controlled trials (RCTs) are acknowledged to provide the most reliable estimate of programme effectiveness, yet relatively few are undertaken in children's services. Consequently, there are few models with a demonstrated impact on child well-being, leading to a concern that services may frequently be ineffective or worse may be harmful. This presentation considers how this state of affairs has come into being and discusses potential remedies for improving both the knowledge base and the quality of interventions. It focuses on 'operating systems' that link prevention science and community engagement thereby helping communities, agencies and local authorities to choose effective prevention, early intervention and treatment models. Specifically, it describes an attempt in Ireland to implement a robust programme of research into children's health and development, to rigorously design new services, evaluate their impact to the highest standard (using RCTs) and integrate the results into the policy process. Based on the authors' extensive first-hand experience of supporting the work, and the advice of international experts, the article reflects critically on the unforeseen challenges and offers lessons learned.

We found that:

- the rigour of service design methods contributes to the rigour of evaluation methods. The specification of estimate outcomes, the target group and a logic model in a sound service design are all pre-requisites for a well-designed RCT.
- coherent and sustained leadership in service development process helps ensure that the logic of the original strategy – including the requirement for experimental evaluations – remains clear to participants over time and at all levels.
- implementing and evaluating proven models should not be seen as an 'easy option' over 'home-grown' designs. They require careful adaptation to fit the local context.
- high levels of technical assistance are required throughout the process to help participants with service design, implementation and evaluation.

c. PREPARING THE WAY: FRONT-END WORK TO SUPPORT THE ROLL-OUT OF AN EVIDENCE-BASED INTERVENTION IN SCHOOLS

Presenter: Dr. Nick Axford, Dartington Social Research Unit, UK

There are more RCTs in children's services today and more evidence-based interventions. But what happens afterwards? Proven programmes are underutilized, reaching only a small proportion of children who could benefit. They are delivered with high quality for even fewer children. Longevity beyond initial testing is rare. This paper considers lessons from efforts in one setting to address these problems. Together for All seeks to improve the behavior and mutual respect and understanding of children in a Northern Ireland community. It includes a curriculum (modified from the PATHS programme developed in the US) to be delivered to six schools in a two-year RCT. This paper focuses on actions to address the factors known to influence the adoption, quality of implementation and sustainability of programmes. It describes the work using the TIES framework for Type 2 translational research:

1. **'T**ranslation stage-setting', for example using epidemiological and focus group data to develop consensus around the need for the service, engaging education national and local policy-makers and securing the support of local head teachers;
2. **'I**nstitutional or individual adoption', including study tours for head teachers to see the programme, and adapting programme materials;
3. **'E**ffective implementation', including appropriate training and recruiting coaches to support teachers;
4. **'S**ustainability' – linking the programme with curricular requirements, engaging education advisers and working to secure long-term government funding.

We found it helpful to: hold a regular Principals' forum starting several months prior to implementation to build support locally and within schools for the programme; to take key administrative staff on a study tour to see the programme in action and understand its underlying logic; to have a teacher amend the programme in consultation with the programme developer; and to make sure that nothing was implemented in the pilot phase that would need to be undone at roll-out.

References

Nutley S. M., Walter, I, & Davies, H. T. O. (2007). *Using evidence: How research can inform public services*. Bristol, UK: The Policy Press

Woolf, S. H. (20008). *The meaning of translational research and why it matters*. Journal of American Medical Association, January 9/16, 211-213.

January 28, 2009
Concurrent Session III
2:00pm - 3:30pm

V. TOWARD THE NATIONAL SCALE-UP OF EFFECTIVE HEALTH PROGRAMS

Room: C1/C2
Session: Think Tank

Chairs:

Wynne E. Norton, PhD Candidate, University of Connecticut
Brian Mittman, PhD, VA Los Angeles Healthcare System

Discussants:

David Chambers, DPhil, National Institute of Mental Health
Janet Collins, PhD, Centers for Disease Control and Prevention
Denise Dougherty, PhD, Agency for Healthcare Research and Quality
Lori Melichar, PhD, Robert Wood Johnson Foundation
Jed Weissberg, MD, Kaiser Permanente

Presenter:

Jim Bellows, PhD, Kaiser Permanente Care Management Institute

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Researchers, service delivery organizations, foundations, and government agencies have developed a rich array of health promotion interventions and healthcare delivery innovations to improve health. Efficacy trials have established strong evidence for many of these innovations; these trials have often led to research on dissemination and implementation strategies designed to facilitate their widespread adoption and routine use in practice settings. Research in this area has produced a growing body of literature documenting successful efforts to implement evidence-based programs in diverse settings.

To date, the majority of studies evaluating dissemination and implementation strategies have been conducted in small- to moderately-sized samples of institutions or communities. The research teams conducting these studies typically provide hands-on technical assistance and implementation support for participating organizations. While feasible for studies conducted in local settings, larger-scale implementation efforts targeting national implementation of effective health practices and programs require different approaches. The gap between research and practice will persist if researchers do not address the challenges of deploying and evaluating implementation strategies at the national level.

Effective national scale-up ("roll-out") of implementation initiatives requires careful planning. Challenges include the need to provide technical assistance to the communities and institutions conducting the implementation effort, facilitating the adaptation and customization of implementation strategies to local needs and circumstances, and obtaining leadership, stakeholder buy-in, political support, and financial commitment.

This session will present critical issues and challenges in the national scale-up of health programs. Formal presentations will include a brief introduction to the topic, followed by three concise case studies of challenges in national scale-up initiatives. Discussants representing key government and private agency stakeholders (including other organizations not formally listed) will discuss the case studies and the broader challenges of national scale-up, leading to an open dialogue and development of ideas, recommendations, and specific objectives for continued attention to these challenges.

January 28, 2009
Concurrent Session III
2:00pm - 3:30pm

VI. CONTEXT: A CHALLENGE TO FIDELITY AND ADAPTATION IN EBP IMPLEMENTATION

Room: F1/F2
Session: Think Tank

Chair/Discussant/Primary Contact:

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Presenters:

Gregory A. Aarons, PhD, University of California, San Diego
Kimberly Eaton Hoagwood, PhD, Columbia University
Phyllis C. Panzano, PhD, Decision Support Services

Contexts within which evidence-based practices (EBP) are implemented are complex, multi-faceted, and fluid. Likewise, EBPs often are complex. Consequently, various tensions arise as individuals, teams, organizations and systems embark on the process of implementing EBPs. Tensions range from allocating scare resources to balancing sustainability and receptivity to change. In the implementation process the context impacts the likelihood that the EBP will be delivered with fidelity (e.g., supervision, monitoring) or that adaptations to the EBP are needed to fit the context. Conversely, the context may need adaptation to fit the EBP.

This Think Tank explores the extent to which contextual factors impact efforts to resolve tensions between fidelity and adaptation pertaining to one EBP and the extent to which contexts might be adapted to EBPs. Definitions of context will be offered to guide discussion. The real-world case study will compare and contrast efforts to implement Dartmouth's Integrated Dual Diagnosis Treatment model (IDDT), with fidelity, within two, different contexts. First, the IDDT implementation unfolds within an adult inpatient facility that participated in a state-led effort to systematically and scientifically adapt IDDT for inpatient use. In the second context, the implementation process proceeds in a community setting and involves a collaborative effort, with grant money, between separate mental health and substance abuse agencies. The case study will highlight differences in initiating circumstances and conditions because these are important aspects of decision-making.

Finding balance, or a 'unity of opposites', between fidelity and adaptation involves consideration of contextual factors, EBP attributes, key stakeholders and more. This Think Tank will focus on aspects of context that are pertinent to this balance. But, *which contextual factors are most relevant?* What is the *right* balance? Using Think Tank team discussion questions, case stakeholder transcripts and survey data, participants will need to draw upon their experiences to fuel discourse.

January 28, 2009
Concurrent Session III
2:00pm - 3:30pm

VII. DESIGNING A RESEARCH TRAINING CURRICULUM IN IMPLEMENTATION SCIENCES

Room: G1/G2
Session: Think Tank

Discussants:

Sanjay Saint, University of Michigan
Joshua Metlay, University of Pennsylvania

Presenters:

Ralph Gonzales, MD, MSPH, University of California, San Francisco
Margaret Handley, PhD, MPH, University of California, San Francisco

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The problem area to be addressed: To create a research training curriculum for implementation and dissemination sciences that has relevance to trainees in academic medical centers from schools of medicine, pharmacy, nursing and dentistry.

Brief description of the case that will be presented to participants: The NIH Clinical and Translational Sciences Awards (CTSA) provide substantial support for academic medical centers to provide clinical and translational research training in doctoral and masters degree granting programs, and represent a major mechanism for training current and future generations of translational scientists. There are currently no well-established curricula for programs to consider for structuring their training of students, residents and fellows in implementation and dissemination sciences within the CTSA programs. There is also a critical need for these programs to provide a bridge to other related disciplines, such as the social and behavioral sciences, health psychology, medical anthropology, economics and health policy.

The specific content area or framework which the chair and each panel participant will present: We will present the results of the strategy we employed at UCSF to develop a T2 research training curriculum for the CTSA-funded Masters in Clinical Research and PhD in Clinical and Translational Research Programs. As a starting point, we will describe the learning objectives and course titles offered (or plan to offer) in T2 research organized around 3 major domains: Methods; Outcomes Research; and Implementation and Dissemination Sciences. Panel discussants will include Program Directors from CTSA-funded institutions pursuing similar training programs.

How the discussion and key emerging issues will be captured and documented for the program committee: We will invite session participants to discuss the overall framework of the training program, its suitability for the diversity of trainees it is designed for, and propose amendments to each section. Final results/conclusions

January 29, 2009
Concurrent Session IV
9:30am - 11:00am

I. MODELS FOR IMPLEMENTING AND SUSTAINING EVIDENCE-BASED PROGRAMS

Room: Balcony A
Session: Panel

Chairs:

Belinda E. Sims, PhD, NIDA
Aleta Meyer, PhD, NIDA
Jacqueline Lloyd, PhD, NIDA

Panelists:

Abigail H. Gewirtz, PhD, University of Minnesota
J. David Hawkins, PhD, University of Washington
Richard Spoth, PhD, Iowa State University

Primary Contact:

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Panel Summary:

The drug abuse prevention field has many examples of efficacious and effective programs that reduce risk factors for substance abuse and related behavioral health outcomes, yet a gap remains in the uptake of evidence-based programs (EBPs) by systems and settings of the target populations. The National Institute on Drug Abuse (NIDA) is very interested in the development and testing of innovative approaches for dissemination, implementation and sustainability of EBPs in real world settings and systems. In this panel, NIDA funded prevention scientists, working in diverse settings and systems, will present models for implementation and sustainability of evidence-based drug abuse prevention programs. The first panel member will present a model for implementation and sustainability of a community prevention operating system based on a randomized trial that is being conducted in 24 mid-size communities. In this study prevention services are targeted to specific community-level risk and protective factors. The second presenter will discuss a model for diffusion of EBPs in rural middle schools through a community-university partnership involving cooperative extension service systems and public school systems. Twenty-eight communities, in two states, are participating in this randomized trial, and sustainability of the infrastructure and implementation are being examined. The third panel member will present a model for nationwide implementation of an evidence-based program that was developed in the US and implemented in an international setting. This study included a train-the-trainer model for program implementers and assessment of fidelity monitoring across generations of implementers. Topics to be covered include development and testing of models for implementing and sustaining evidence-based programs,

building capacity for large scale implementation, fidelity monitoring, and factors that influence program implementation and sustainability (e.g., characteristics of communities and community teams, organizational characteristics, quality of implementation, training and supervision, etc.).

Individual Presentations:

a. IMPLEMENTING EVIDENCE BASED PREVENTION: LESSONS FROM COMMUNITIES THAT CARE

Presenter/Primary Contact:

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Tobacco use, alcohol use, and delinquent behavior increase dramatically in the population in incidence and prevalence during early adolescence and have large costs to society. Effective programs for preventing these problems have been developed and tested over the past quarter century, but are not widely used. Strategies for translating advances in effective prevention programming into community prevention systems are needed. The Communities That Care (CTC) prevention operating system provides manuals, tools, training, and technical assistance that activate communities to use advances in prevention science. CTC promotes the use of local epidemiologic data to guide local selection of preventive interventions, encourages the selection and use of tested and effective preventive interventions matched to community need, and promotes the implementation of these interventions with fidelity. This presentation describes results of a five year 24 community randomized trial of the CTC system and implications of these results for efforts to disseminate tested and effective preventive interventions.

Primary Funding Source: National Institute on Drug Abuse - R01-DA015183

b. PROSPER PARTNERSHIPS FOR QUALITY IMPLEMENTATION AND SUSTAINABILITY

Presenter/Primary Contact:

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Mark Greenberg, Ph.D, Pennsylvania State University

PROSPER is an evidence-based model for community-university partnership delivery of evidence-based programs (EBPs) through which community teams collaborate closely with prevention coordinators and scientists, providing proactive, continuous technical assistance. It is grounded in a 19-year program of translational research that addresses the challenge of building capacity for scaling up EBPs. Central to its capacity building is the linkage of two existing delivery systems that reach every community in the country—the Land Grant University Extension System and Public School Systems.

The presentation will begin with an overview of the PROSPER approach to barriers and opportunities in scaling up EBPs. Essentially, PROSPER serves as a support system for meeting the multiple challenges and demands of community mobilization, selection and quality implementation of EBPs, long-term sustainability, plus ongoing process and outcome evaluation. Accordingly, interrelated sets of strategies for addressing these specific challenges and demands will be outlined.

The PROSPER Project research design and procedures also will be described—a sequential cohort, randomized, controlled study of 28 school districts in Iowa and Pennsylvania. A summary of key findings will be presented, including results on EBP recruitment from general populations, quality of EBP implementation, and local sustainability of interventions. Correlational study of factors that influence recruitment, implementation quality and sustainability will be reviewed. Substance use and other outcomes at long-term follow-up assessments will be highlighted.

Finally, there will be an overview of future directions in model testing and evaluation of the sustainability of community implementation teams and EBPs. A design for an expanded network of partnerships will be provided.

Primary Funding Source: National Institute on Drug Abuse - R01-DA013709

c. MIDNIGHT SUN TO GREAT LAKES: TAKING PMTO TO SCALE IN NORWAY AND MICHIGAN

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This presentation provides an overview of a model for international as well as local implementation of Oregon Parent Management Training. Oregon Parent Management Training (PMTO) is a theoretically-grounded, principle-based intervention for the prevention and treatment of conduct problems (Patterson, 2005; Reid, Patterson, & Snyder, 2002). Developed by Gerald Patterson and colleagues at Oregon Social Learning Center, PMTO interventions have been well-validated in improving parenting, child adjustment and family functioning among a range of populations including universal populations, children raised by single or divorcing parents, low-income parents, maltreating parents, incarcerated parents; delinquent youth, and children with early onset conduct problems (Patterson, 2005; Reid, Patterson, & Snyder, 2002; Kazdin, 1997; Chambliss & Ollendick, 2001; Brestan & Eyberg, 1998).

International dissemination of PMTO began in the 1990s, with an invitation from the Norwegian government to implement PMTO throughout that country. The implementation project was funded by the Norwegian government with a plan for PMTO ultimately to be self-sustaining, initially by training three cohorts of a first 'generation' of mental health professionals throughout the country. Concurrent research funding from NIDA enabled the examination of fidelity and sustainability across subsequent generations of trainees. A randomized clinical trial in Norway demonstrated PMTO's effectiveness (Ogden, 2008). Four generations of PMTO specialists have now been trained in Norway, and a fifth is underway. Infrastructure development for this project included extensive adaptation and manualization of training materials for 18 workshop days, the creation of a coaching structure and coaching materials, and the development of extensive infrastructure to assess fidelity and certify professionals based on observed, specific standards of care. The PMTO model has also been implemented statewide in Michigan, with a current focus on the Detroit-Wayne County metro area. An overview of this project will be provided, with similarities and differences highlighted to demonstrate emerging questions in implementation science.

Primary Funding Source: National Institute on Drug Abuse - R01-DA016097; Substance Abuse and Mental Health Services Administration - 5U79SM056177

January 29, 2009
Concurrent Session IV
9:30am - 11:00am

III. EVIDENCE-BASED PRACTICE IN REAL WORLD SETTINGS

Room: Balcony B
Facilitator: Redonna Chandler, PhD, NIDA

Individual Presentations:

a. IMPLEMENTATION OF EVIDENCE-BASED PRACTICES IN CHILD SERVICE SYSTEMS

Presenters:
Patricia Chamberlain, PhD, Oregon Social Learning Center, pattic@cr2p.org
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Todd Sosna, Ph.D, California Institute for Mental Health
Wei Wang, Ph.D, University of South Florida

Strategies, influences, and measurement models in a 40-county randomized trial of an evidence-based practice for youth in foster care, Multidimensional Treatment Foster Care (MTFC), within child welfare, mental health, and juvenile justice systems in California will be described including: a) qualitative data on the influences of social networks among key decision makers, and b) the use of a structured instrument designed to assess stages of implementation completion. In the qualitative study, grounded theory analytic methods were used to analyze semi-structured interviews with 38 agency directors representing the Mental Health, Child Welfare, and Probation Departments in 13 California counties. Three primary themes were found: 1) agency directors developed and maintained networks of information and advice based on roles, geography, and friendship ties; 2) collaboration was viewed as critical to implementing EBPs, particularly when resources are limited; and 3) requirements for effective collaborations included social ties, sufficient and equal distribution of funds, a common culture that includes a "can do" philosophy, common priorities and language for communication, willingness to give up some administrative control, an integrated organizational structure, and nurturing relationships that promote values necessary for an effective organizational culture. The structured instrument, the Stages of Implementation Completion (SIC), is an ordinal scale designed to measure progress through 8 stages, from initial engagement to program sustainability; it utilizes multiple indicators to assess movement toward successful implementation. County progress through implementation is measured by the number of stages completed, including time required to complete the tasks within each stage and a quality rating of the completed tasks. Preliminary data will be presented on the psychometric properties of the measure. The study is funded by the Dissemination and Implementation Research Program Division of Services and Intervention Research at the NIMH, the DHHS Administration of Children and Families, and the WT Grant Foundation.

b. A NATIONAL MODEL FOR FUNDER-RESEARCHER-PROVIDER EBP IMPLEMENTATION

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Co-Authors:

M.L. Dennis, PhD; S.H. Godley, RhD; and M.D. Godley, PhD; Chestnut Health Systems

NIDA's blue ribbon panel on health services research has noted the substance abuse treatment field is facing increasing demands from payors, policy makers, and the public at large for evidence-based practices that can effectively reduce substance use and its negative consequences. Since September 2006, the Center for Substance Abuse Treatment (CSAT) has awarded 32 grants to implement three evidence based practices for adolescents with substance use disorders . These practices include: 1) a standardized biopsychosocial assessment known as the Global Appraisal of Individual Needs (GAIN); 2) the Adolescent Community Reinforcement Approach (A-CRA) and 3) Assertive Continuing Care (ACC). The GAIN has been used extensively for patients with substance use disorders (Dennis et al., 2003). Both of the behavioral interventions received empirical support in several randomized clinical trials (Dennis et al., 2004; Godley et al., 2007; Sleznick et al., 2007; Godley et al., under review). These approaches have been developed and evaluated with funding from CSAT, NIAAA, and NIDA. CSAT's goal is to facilitate the implementation of evidence-based practices and ensure sustainability over time. Toward this end, the developers use a comprehensive approach to training and quality assurance with several clinical staff from each participating provider organization, some of whom agree to undergo a train-the-trainers approach in order to sustain each practice beyond the grant period within their organization. This presentation will a) provide a brief historical overview of CSAT's commitment to science-to-service initiatives within its adolescent treatment grant portfolio; b) illustrate this commitment by describing the training and quality assurance methods employed in the Assertive Adolescent and Family Treatment initiative; and c) discuss implications and recommendations for the transfer of evidence-based practices to those who treat substance use disorders.

Primary Funding Source: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment

c. IMPLEMENTING HOSPITAL-ACQUIRED INFECTION PREVENTION PRACTICES

Presenter/Primary Contact:

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Objectives: Healthcare-associated infection (HAI) is a common patient safety problem. U.S. hospitals will no longer receive Medicare reimbursement for certain HAIs thereby heightening the need for effectively implementing infection prevention practices. The mere existence of evidence-based practices, however, does not equal the use of such practices. We sought to understand the barriers to implementing practices to prevent HAI with a specific focus on the role played by hospital personnel.

Methods: We conducted a multi-center qualitative study with data collected through in-depth phone and in-person interviews with personnel at 14 diverse U.S. hospitals. We interviewed 86 people including: Chief Executive Officers, Chiefs of Staff, Hospital Epidemiologists, Nurse Managers, and front-line clinicians. Each interview was transcribed and independent summaries were prepared for each site by team members who then met to discuss findings.

Results: Active resistance involving hospital personnel, who vigorously and openly opposed various changes in practice, increased the difficulty of implementing practice change and was pervasive. Successful efforts to overcome active resisters included benchmarking infection rates, identifying effective champions, and participating in collaborative efforts. Organizational constipators – mid- to high-level executives who act as insidious barriers to change – also increased the difficulty in implementing change. Recognizing the presence of constipators is often the first step in addressing the problem but can be followed by including the constipator early in group discussions in order to obtain buy-in or working around the individual.

Conclusions: We identified certain personnel that impeded HAI prevention activities. We also identified approaches used by hospitals to overcome these barriers to change, such as providing benchmarked data, identifying local champions, and addressing organizational constipators through early communication and engagement.

Impact: Hospital administrators and patient safety leaders can use these results to more successfully structure activities that prevent HAI in their hospitals with the ultimate aim of enhancing patient safety.

January 29, 2009
Concurrent Session IV
9:30am - 11:00am

III. IMPROVING IMPLEMENTATION QUALITY

Room: Balcony C
Facilitator: Jennifer Brown Urban, PhD, OBSSR

Individual Presentations:

a. A LOW-COST MODEL FOR IMPROVING IMPLEMENTATION QUALITY

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Introduction: There is considerable evidence of the variability of implementation quality as efficacious programs go to scale. As implementation quality has been correlated with program outcomes, this variability brings into question the power of these programs to effect public health improvement. The traditional paradigm for disseminating programs involves a brief (one or two day) pre-implementation training, with actual implementation sometimes following weeks or months later, and (sometimes) coaching or support made available on an "as-needed" basis.

This study tested the efficacy of a low-cost, low-intensity form of proactive coaching and support, utilizing distance learning technology during the period of implementation. The hypothesis was that teachers who participated in this low-intensity implementation support would demonstrate better quality of program delivery.

Methods: 18 classroom teachers from 6 schools were randomized to intervention or comparison conditions. All teachers were trained together in the LifeSkills Training middle school drug prevention curriculum and implemented the program over the course of a school year to approximately 2,000 6th-9th grade students. During the period of program delivery, intervention teachers participated in a weekly 20-minute facilitated group discussion of that week's lesson(s) via web-conference. A brief (2-3 minute) podcast overview of each lesson was also made available for intervention teachers to access on the day they were scheduled to teach a lesson. These two brief strategies constituted the intervention.

Teachers in both conditions completed a baseline survey to assess potential group differences. During the period of program delivery, videotaped observations were collected for all lessons in both conditions and teachers completed a self-report of implementation quality after each lesson. Videotaped observations were coded for implementation quality and fidelity by nationally-certified LST trainers. Students also completed a self-report survey pre- and post-intervention to measure program impact.

Findings: After controlling for dosage, intervention teachers demonstrated higher levels of implementation quality and fidelity as measured both by self-report and by coded observation. Students showed a significant main effect on relevant measures of drug use knowledge, decision-making and life skills, although no implementation intervention effect was found at the student level. This pilot efficacy study demonstrated that a very low-cost and low-intensity model of implementation support could improve the quality of delivery of an evidence-based intervention. The model tested is generalizable to other prevention programs and its cost and non-invasive nature make it an attractive alternative to the standard pre-implementation training model.

Acknowledgements: This research was supported by a grant from the Pennsylvania Commission for Crime and Delinquency (PCCD). Findings and recommendations herein are those of the author and not official statements of PCCD.

b. IMPROVING PROGRAM IMPLEMENTATION: CONSUMER PREFERENCE AND OUTCOMES

Presenter/Primary Contact:

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Consumer service preferences influence the success of program implementation in community-based mental health services. When services offered do not comport with consumer preferences, services are likely to be underutilized, less than optimally effective and possibly opposed by advocacy groups. On the other hand, services that do not reflect clinicians' recommendations may be implemented poorly, fail to receive sufficient funding and diverge from evidence-based practices.

Research Question: Do the housing preferences of homeless persons diagnosed with serious mental illness diverge from clinician housing recommendations and can outcomes be improved by a preference-based housing placement policy?

Methods: The Boston McKinney Project measured both homeless consumers' housing preferences and clinicians' housing recommendations and then randomly assigned the consumers to either independent living or group homes. Outcome measures included housing retention, cognitive functioning and consumer satisfaction. Preference surveys conducted in multiple Boston area homeless programs indicate generalizability.

Findings: McKinney consumers' housing preferences diverged sharply from clinician recommendations. After they moved into project housing, those in independent living sites were more satisfied with their residence than those in group homes but more likely to lose their housing and decline in cognitive functioning. Consumers who moved into group housing gradually increased their preference for group

housing. Clinicians tended to underestimate consumers' ability to live independently, but consumers who preferred independent living when clinicians recommended group homes were most likely to lose their housing.

Conclusions: Preference-based housing assignments do not improve outcomes, but must be taken into account. Housing orientation programs may reduce consumer-clinician dissonance and lessen the risk of housing loss. Specialized housing for substance abusers is also needed to lessen housing loss. Assessing and responding to consumer preferences and clinician recommendations will improve implementation of evidence-based programs.

Funding: National Institute of Mental Health; Edith Nourse Rogers Veterans Administration Medical Center; University of Massachusetts Boston; Commonwealth Research Center, Harvard Medical School.

c. MARKETING DEPRESSION INTERVENTIONS FOR ADOLESCENTS IN PRIMARY CARE

Presenter/Primary Contact:

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Background: Adolescent depression is both common and burdensome. While evidence-based strategies have been developed to prevent adolescent depression, participation in such interventions remains extremely low, with less than 3% of at-risk individuals participating. Such evidence-based preventive strategies need to be encapsulated in a rigorous marketing strategy if they are to be translated into practice.

Objective: To develop and evaluate the feasibility and effectiveness of a rigorous marketing strategy for engaging at-risk individuals with an Internet-based depression prevention intervention in primary care.

Methods: A marketing design group consisting of physicans and emerging adult research assistants developed a social marketing strategy (targeting, positioning/competitor analysis, decision analysis, and promotion/distribution) incorporating contemporary models of behavior change. We evaluated the formative quality of the intervention, implementation feasibility, and evidence of effectiveness in enhancing adolescent motivation for prevention using an observational study design.

Results: The marketing plan focused on the theme of "resiliency building" rather than "depression intervention" and was relayed by office staff and the Internet site. Twelve practices successfully implemented the intervention and recruited a diverse sample of adolescents with > 30% of all those with positive screens for mild depression and > 80% of those eligible after a brief phone asssement enrolling in the study with a cost of $58/enrollee. Adolescent motivation for depression prevention (1-10 scale) increased from a baseline mean value of 7.45 (SD= 2.05) to 8.07 post study (SD=1.33), p=0.048.

Conclusions: Preventive interventions for mental disorders can be developed and successfully introduced and marketed in primary care. Such strategies may incease levels of participation in prevention studies and strengthen motivation.

Acknowledgments: Supported by a NARSAD Young Investigator Award, Robert Wood Johnson Foundation Depression in Primary Care Value Grant, and a career development award from the National Institute of Mental Health (NIMH K-08 MH 072918-01A2)

January 29, 2009
Concurrent Session IV
9:30am - 11:00am

IV. ONE SIZE DOESN'T FIT ALL: DISSEMINATING TO UNIQUE HIV SERVICE AGENCIES

Room: Main Auditorium
Session: Panel

Chair: Carlo DiClemente, PhD, University of Maryland Baltimore County

Panelists:

Jennifer Betkowski, MA, University of Maryland Baltimore County
Henry Gregory, PhD, University of Maryland Baltimore County
Lisa Jordan-Green, PhD, University of Maryland Baltimore County
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"Bridging the gap between science and service" is the ultimate goal of the university-community collaboration at University of Maryland Baltimore County's Center for Community Collaboration. Through the use of empowerment and capacity building models, we are able to disseminate knowledge of best practices in the fields of mental health, substance abuse, and treatment adherence to those working in the HIV service communities. The delivery of this information is unique to each agency as we tailor our training to be congruent with the culture in every organization and of the clients. This ensures that we deliver individualized guidance to meet the agency's needs. Our organization-specific training approach builds trust between the university and community agency, motivates the agency for change, and allows the agency to claim ownership in their growth. We will describe the approach and highlight two very different case examples. These two organizations presented with very diverse populations, needs, and barriers, yet our flexible training model was able to effectively build upon each agency's strengths to advance mental health and substance abuse treatment in an HIV-positive populations.

Individual Presentations:

a. EMPOWERMENT AND CAPACITY BUILDING IN HIV SERVICE AGENCIES

Empowerment and capacity building in HIV service agencies The Center for Community Collaborations (CCC), based in the Psychology Department at the University of Maryland Baltimore County, has for the past three years been working to disseminate an empowerment-based model for training and increasing capacity of staff members within community-based organizations that serve HIV+ clients. This model has been created and delivered in partnership with the Maryland AIDS Administration, who commissioned the CCC to work with community-based organizations to assist them in the implementation of evidence-based practices for mental health problems, substance abuse, and treatment adherence. The University-community partnership brought together the expertise on the latest interventions and their applications with the knowledge of the community, its culture, history, and specific needs.

The Empowerment and Capacity-building models have been used successfully in other contexts to train HIV service providers and supervisors, especially those that serve ethnic minority communities (Poindexter, Lane, & Boyer, 2002; Ramos & Ferreira-Pinto, 2002). These models have generally been developed and implemented within the context of collaborative relationships between universities, AIDS Bureaus and/or state-based health associations. The appeal of the Empowerment and Capacity-building models is that they emphasize the existing strengths of community-based agencies, and provide an environment in which new information can be incorporated by building on those strengths.

Our experience in working with agencies and our satisfaction surveys indicate that agency staff are receptive to the training model, that it addresses their needs both as agency staff and sometimes personally, and that it differs from the training experiences that they have typically had in the past. This presentation will outline the primary objectives and methods of the training approach, present some of our evaluation data, and discuss the challenges and successes we have experienced in getting agency staff to adapt evidence-based approaches (e.g., Stages of Change, Motivational Interviewing) into their work with clients.

b. THE ROLE OF CULTURAL COMPETENCE IN DISSEMINATION

The CCC uses a multifaceted approach to cultural competence to ground its efforts to disseminate information and evidence-based interventions to the variety of HIV programs that it supports with capacity building services and training. Cultural competence, the delivery of services to diverse populations in ways that are both effective and acceptable to the consumer, is critical when targeted programs are laboring under the stress of increased workloads, higher levels of accountability to multiple funders, under-trained staff and clients that are more needy.

The CCC designs its trainings to be consistent with the cultural tendencies of the agencies with which it works, which are often staffed largely by African-Americans. African-Americans tend to prefer direct interpersonal contact and to be relationship-oriented, spiritual, affectively inclined, and grounded in oral tradition (Nichols, 1976).

Considering the importance of relationships to this community, the CCC uses a very interactive training format and continually reviews its post-training evaluations to assess and respond to participants' perceptions of the presenters.

Culture differences also manifest as professional disciplines, age, experience, education, gender, sexual orientation, HIV exposure, etc.

Looking at dissemination and implementation through the lens of culture helps us to understand the learning styles, treatment assumptions and orientation, preferences and biases of managers and staff that may manifest as resistant to change. It also helps us to customize the interventions to suit the audience. Many managers and staff feel overwhelmed by the demands of diverse clients and requirements of various funding sources.

Two evidenced-based intervention models, Motivational Interviewing and Stages of Change, are the underpinnings of the content and processes of our trainings. Capacity building and training is a parallel process of engaging managers and staff using the same reflective, empowering process with them that they are encouraged to use with their clients.

c. CASE EXAMPLES IN COLLABORATIVE DISSEMINATION

The CCC offered a variety of training and capacity building services to disseminate empirically supported substance abuse and mental health approaches with a diverse group of agencies caring form HIV positive clients. Our needs assessments indicated that the optimal set and structure of services differed widely by agency interests and structure.

Agency A (a comprehensive care clinic serving a large homeless population) and Agency B (a small community organization for an underserved LGBT population) provide a clear contrast regarding dissemination needs and strategies.

Agency A's challenges involved serving a transient client population with several tangible and adherence needs (e.g., monetary demands, time-management). We had to tailor training content accordingly, by focusing on strategies for client engagement (i.e., Motivational Interviewing and reflective listening). We also had to focus on applications central to their experiences including combative clients and demands for quick resolutions. Additional challenges involved staff diversity. To build strengths and interest, we needed different roles for more experienced trainees. The director was interested in agency-wide adoption, so we needed trainings and resources for systems generalization. There were opportunities for inter-disciplinary meetings, requiring both medical and non-medical applications.

Agency B's challenges included staff resources and professional development. The founding director had a small staff with little to no mental health or substance abuse training. The director had a separate full-time job and thus restricted ability to focus on program development. Although passionate about leadership, he struggled to effectively delegate tasks. There also was little staff collaboration, hindering productivity. Thus, we chose to focus on direct capacity building in research/administration, strategic planning, and group facilitation. We offered basic trainings in substance abuse and mental health with a focus on engagement, referrals and brief interventions. We also provided direct client services to model and initiate formal service provision. We spent substantial time on group processing and restructuring, involving the staff in packaging disseminated information about strategies to be used with clients.

This presentation will describe and contrast application of our community collaboration model of dissemination to these two different agencies. We will highlight approaches and barriers and the tailoring process for capacity building.

January 29, 2009
Concurrent Session IV
9:30am - 11:00am

V. SYSTEMS THINKING FOR IMPLEMENTATION RESEARCH AND PRACTICE

Room: C1/C2
Session: Think Tank

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Increased awareness that implementation is often a complex, dynamic, and multidimensional process, has led many researchers and practitioners to turn to systems thinking as an alternative paradigm for addressing implementation challenges. Systems thinking is a promising scientific approach that provides a myriad of new tools, methods, and principles with potential to address many of the key challenges facing the field of implementation sciences. To fully benefit from systems thinking, however, additional work is needed to better understand how to apply this approach to implementation efforts.

The overarching goal of this think tank is to explore systems thinking and its application to implementation efforts in order to maximize its potential value in this field. A decision-process framework will be used to guide the think tank participants through sequential steps for considering the value and need for systems thinking, barriers to its application, and strategies for overcoming these barriers. The think tank session will begin with a presentation introducing the systems thinking perspective (10 min), followed by two brief presentations illustrating the application of this perspective (10 min each). These will be followed by a series of thematic-discussions based on three subthemes (15 min/subtheme) capturing key facets of the goal for improving use of systems thinking, and concluding with a discussion (15 min). The subthemes will be used to organize the discussion and subsequent documentation of key emerging issues.

The anticipated outcome of the discussion is a clearer picture of the potential for systems thinking in implementation research and practice.

Subtheme 1: What makes various implementation problems complex? What are the problems or gaps in current methods for studying and managing implementation efforts?

Subtheme 2: What are some of the system structures/characteristics that need to be considered in implementation efforts?

Subtheme 3: How can systems principles be applied to improve implementation efforts?

January 29, 2009
Concurrent Session IV
9:30am - 11:00am

VI. MONITORING FIDELITY TO TREATMENT MODELS IN LONGITUDINAL DISSEMINATION RESEARCH

Room: F1/F2
Session: Think Tank

Chair/Presenter/Primary Contact:
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Discussant:
John Kimberly, PhD, The Wharton School, University of Pennsylvania

Research on factors related to the long-term adoption of evidence-based practices is an important yet challenging area of research. One of the most challenging aspects of the research is the implementation of a method of assessing the level of fidelity to a treatment model and competence in using that model over the long term. Some of the factors that make such research difficult to pursue include 1) tracking research participants over a follow-up period that is sufficiently long to monitor their use of the new intervention 2) measuring fidelity and competence through objective measures under naturalistic conditions 3) characterizing the extent to which the adoption is sustained in a meaningful, non-dichotomous manner. Dr. Stirman will review prior research that has attempted to monitor fidelity and competence, and will present a longitudinal examination of the use of cognitive therapy in community-based settings to illustrate some of the challenges. Dr. Kimberly will highlight some of the challenges in studying the sustainability of innovations in health care settings and will end the meeting with a summary of key points raised during the group discussion. These key points will be documented for the program committee in a brief paper that highlights the key elements and emerging issues reached by the group.

January 29, 2009
Concurrent Session IV
9:30am - 11:00am

VII. SUSTAINING COMMUNITY MENTAL HEALTH CONSULTATION TO URBAN SCHOOLS

Room: G1/G2
Session: Think Tank

Chair/Primary Contact:

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Kimberly Eaton Hoagwood, PhD, Columbia University

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This *Think Tank* will address barriers and facilitators to the implementation of effective programs in schools and community agencies in high poverty urban communities. Mental health consultation to urban schools is widely acknowledged as a promising intervention to close the persistent gap in service use for children living in poverty (Cappella et al., 2008, *Administration & Policy in Mental Health & Mental Health Services Research, 35:395-409*). However, there is little or no research that describes the complexity of implementing and sustaining effective school-community models. This issue will be addressed by examining the implementation of *Links to Learning*, an NIMH-funded study (PI: Atkins) currently in its 4th year, that aligns community providers with parents and teachers to address key predictors of academic and behavioral functioning for children in urban high-poverty schools. The training of community providers will be described, highlighting components of the model that appeared most and least compatible with traditional mental health practice. Dr. Mehta, primary consultant to the agency, will present the university perspective, and Dr. Williamson, agency supervisor and clinical director, will present the agency perspective on program adoption and sustainability. Dr. Schoenwald, Co-I of the grant, will present conceptual and methodological issues related to intervention fidelity and transportability. Dr. Atkins will moderate the discussion focused on: 1) Intra- and inter-organizational factors that impact school-agency collaboration, 2) supervision models to enhance agency capacity; and 3) research strategies to capture the critical domains of program adaptation,

implementation, and sustainability. Dr. Hoagwood, PI of an NIMH developing center on implementation of evidence-based practices for state mental health systems, will provide a summary of key issues discussed and address implications for advancing policy, research and practice for the sustainability of effective community mental health services in high poverty urban communities.

Primary Source of Funding: National Institute of Mental Health R01MH073749, P20MH078458

Poster Session List and Abstracts

Poster Session List and Abstracts

January 28, 2009

1. **EVIDENCE-BASED PRACTICE AND U.S. SCHOOL NURSING**

Presenter: Susan Adams, PhD, RN
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Abstract

Background: Research on the adoption of evidence-based practice (EBP) in healthcare has focused mainly on hospital settings and primary care; little is known about EBP dissemination and implementation among school nurses.

Objective: The purpose of this study was to describe the prevalence of EBP use, to describe demographic, individual and organizational factors associated with EBP use by school nurses and to identify resources needed to advance EBP use among school nurses.

Methods: A survey designed for this study, the School Nurse Evidence-Based Practice Questionnaire (SN-EBP) was mailed to all school nurses in Iowa, USA with a response rate of 56.8% (n=386). Descriptive statistics and t-tests were used to describe the variables of interest. Multiple regression and analysis of variance were used to identify factors that explain the variance in use of EBP.

Results: Analyses indicate that information sources, professional membership, and district size explain a significant amount of the variance in current use of EBP by school nurses. Resources needed to increase use of EBP included availability of networking opportunities with other school nurses, pre-developed EBP guidelines and education on outcome evaluation. Nurses identified four stakeholder groups that impacted implementation of EBP: 1) Peers, 2) Support Staff (e.g. custodians, food service personnel) and 3) Principal Players (e.g. Principal, teachers), 4) External Support (e.g. Administration, PCPs, Parents).

Discussion: This study provides important information on variables that impact current practice in school nursing, and also identifies resources requested by school nurses for increasing their use of EBP. Respondents provided baseline information on EBP including level of current use, awareness, and skills, and also identified frequently used information sources. These results were used to develop a beginning conceptual model that will guide testing translation strategies to increase the use of EBP in the school setting.

Funding for this study was provided by grants from Sigma Theta Tau, Gamma Chapter and The National Association of School Nurses.

2. RCI'S ONLINE EVIDENCE-BASED CAREGIVER INTERVENTION RESOURCE CENTER

Presenter: Marni S. Amsellem, PhD

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Abstract

Many programs aim to improve the health and well-being of caregivers, but the efficacy of a significant number of programs already in use has never been evaluated. Implementation of existing interventions in additional caregiver settings would best be accomplished after evaluating the evidence base and identifying a program that matches the target goals and population. Furthermore, many existing evidence-based interventions that are ready for dissemination to be adapted outside of the research context often are not disseminated. Because a systematic means of both disseminating and searching for an appropriate evidence-based intervention previously did not exist, the Rosalynn Carter Institute (RCI) developed an online resource for disseminating and implementing evidence-based interventions to improve caregiving over the past year. The goal is to increase the use of "science that works" to support both professional and family caregivers.

The Evidence-Based Caregiver Intervention Resource Center provides detailed information on interventions that have been tested in a randomized controlled trial (RCT) and have been found to positively impact caregiver outcomes. It is a searchable clearinghouse that is updated regularly. Interventions were identified from a comprehensive literature search of peer-reviewed publications as well as supplemental manual review of relevant outcome papers. Interventions that had a statistically significant effect on at least one outcome that directly impacted caregivers were further reviewed. The lead author of the outcomes study was contacted and asked to submit detailed information regarding implementation of the intervention in other settings.

The Resource Center is active on RCI's website at http://www.rosalynncarter.org/dynamic_grid/. Interventions are searchable by the illness/disease population and describe the program, link to implementation key points, and list expected outcomes. Interested agencies and individuals can review the interventions and implementation recommendations contained within to make informed decisions about which they might like to implement in their own community.

Primary source of funding: Johnson & Johnson/ RCI Caregivers Program

3. TRANSLATING INTERVENTIONS FOR RACIAL/ETHNIC MINORITY COMMUNITIES

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Abstract

Objectives: This presentation will describe the findings from a collaborative project between the Prevention Research Center National Community Committee and Saint Louis University School of Public Health. We will describe the process and outcome of a concept mapping process used to identify practice recommendations for translating evidence-based physical activity interventions with and within racial/ethnic minority communities.

Method: Concept mapping was used to identify a list of issues to consider when adapting evidence based physical activity programs. A list of recommendations for demonstration projects to use in adapting evidence-based interventions to their local context was created from these findings. Qualitative interviews from demonstration projects and content analysis of published works were used to identify how the practice recommendations were operationalized in translating evidence-based physical activity interventions.

Results: The concept mapping process identified several recommended practices for translating evidence-based physical activity interventions into racial/ethnic minority communities (e.g., attend to culture, tailor interventions, consider local infrastructures). The presentation will present this list and how these have been operationalized in current and previous work.

Conclusions: In order to translate evidence–based physical activity interventions with and within racial/ethnic minority communities it is important to intentionally modify approaches to meet the needs of the local community with respect to both population and context. One important lesson learned from our work is the importance of recognizing the role of social determinants (race/racism, class/classism, education, employment) when translating interventions. It is important to address social determinants when tailoring an intervention in not only surface ways for example by modifying the reading level of a brochure but also by making them a more explicit part of the intervention for example by recognizing how racism affects trust, and how trust affects understanding and hearing messages about physical activity.

Acknowledgement: We would like to acknowledge our project officer, Refilwe Moeti for her support and contributions to this work. This work was funded by the Center for Disease Control and Prevention, Prevention Research Center.

4. IMPLEMENTING 21ST CENTURY WELL CHILD CARE IN AN HMO

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Abstract

We describe a theory and evidence-based process for implementing developmental and preventive services for children. Twenty first Century Well Child Care (WCC) is a parent-centered, multidisciplinary team-based model combining online pre-visit child assessments with in-office well child visits of varying length. Parents complete pre-visit assessments using the Child Health and Development Interactive System (CHADIS), a web-based screening and assessment tool.

Implementation of WCC at two pediatric clinics has begun, with plans for dissemination throughout the HMO, guided by the PRISM model (practical, robust, implementation, and sustainability model). Sociometric ("who to whom") questionnaires administered to providers identified which among them function as advice-sources (opinion leaders) for WCC innovations. Provider Focus groups were conducted to understand potential barriers and facilitators to implementation of WCC, emphasizing operational issues such as appointment scheduling.

Social network map data identified key personnel at each implementation site based on the network centrality metrics of betweeness, power, and network reach. These individuals will be provided with social marketing messages and materials with which they can communicate to their colleagues, promote positive characteristics of the WCC model, address barriers to implementation, and encourage colleagues to adopt WCC. Focus group results pointed to the need for a WCC model that is member-centric, logistically feasible (e.g., multiple modes of completing pre-visit assessment, compatible with current appointment scheduling procedures), flexible (offering choice of provider and visit type), with visits tailored to the needs of children and their parents (e.g., longer visits for children with special health care needs), and that addresses providers' time constraints both at the visit and in pre- and post-visit documentation.

Using a hybrid strategy including the PRISM model, social network analysis, and qualitative research, we identified key personnel for implementation and dissemination, and developed important messages for promoting the change and addressing potential barriers to the process.

Funding Source: Commonwealth Fund, grant #20080150 & Kaiser Permanente Colorado

5. EVIDENCE-BASED HEALTH POLICY: LESSONS FROM 3 RESEARCH-FOR-POLICY INNOVATIONS IN THE NETHERLANDS

Presenter: Marleen Bekker, PhD

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Abstract

Aim: (1) to inductively analyze public health research-policy interactions in specific contexts in order to (2) improve those interactions for specific purposes as well as develop models for analysis.

Question: How is evidence for policy perceived and enacted, and what are the consequences?

Methods: (a) literature review of the relationship between evidence and policy from policy and governance literature, science and technology studies, and organizational sociology; (b) interpretative approach using a qualitative multiple case-study design, combined with survey analysis and game simulations as a research tool and as a training tool.

1) Health Impact Assessment for Healthy Policies: process management of perceptions
   Object: Evaluating HIA of national and local policies and projects
   Results—
      Outcome: policies hardly HIA-based.
      Causes: technical design ignores political-normative issues; lack of institutional infrastructure.
      Indication: Reflective process design creates more preconditions for evidence-based decisions than technical design only.

2) Public Health Status and Forecast: building frontstage and backstage support
   Object: Evaluating the quadrennial monitor report informing national health policy papers
   Results—
      Outcome: evidence-based health policy.
      Causes: Front stage division of labour using scientific transparency, conditioned by (1) backstage informal negotiation of research and policy mandates, and (2) supportive infrastructure mobilizing scientific authority.

3) Academic Collaborative Centers for Public Health: institutionalizing impact
Object: Evaluating 9 contracts between academic research departments, Community Health Services and municipalities
Results 1st exploration phase—
Variation in topics covered and networks mobilized, yet similar emphasis on scientification of practice. ACC as 'boundary organization' appears to be supportive infrastructure, policy input needs to be strengthened. Potential for developing Communities of Practice enhancing legitimate public health interventions.

Implications:

1. For analyzing research-policy interactions:
   - Research-policy interactions are best analyzed with a combination of recent insights from policy, sociology of science and organizational studies, each of the schools alone tends to ignore relevant aspects of those interactions.
   - A detailed analysis of frame perceptions, challenges and responses, and context enables the identification of a gradual evolution towards or away from evidence-based policies, including institutional capacity-building.

2. For public health researchers, policymakers and practitioners:
   - In the absence of institutional incentives, cross-frame reflection on the part of researchers as well as policymakers is crucial in generating conditions for evidence-based policies: building stable social relations precedes substantial consensus-building.
   - Building and sustaining legitimate public health practice rests on technical excellence as well as process management and an authoritative network infrastructure including primary and secondary user groups.

[1] Bekker, Putters & Van der Grinten (2007). This research was supported by the Netherlands Organization of Health Research and Development [ZonMw grant numbers 2100.0084 and 6010.0954,03]

[2] Van Egmond, Bekker, Bal & Van der Grinten (2006). This research was supported by the National Institute of Public Health and the Environment (RIVM).

[3] Wehrens, Bekker, Bal, Van Egmond & Putters (2008). This research is supported by the Netherlands Organization of Health Research and Development [ZonMw grant number 7150.0001]

6. COMMUNITY COALITIONS AND HIGH-QUALITY PROGRAM IMPLEMENTATION

Presenter: Louis D. Brown, PhD

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Abstract

Objective: Implementing evidence-based programs (EBPs) in community settings with fidelity is a substantial challenge. Community prevention coalitions represent a promising strategy for supporting the implementation of EBPs (Feinberg, Greenberg, Osgood, Sartorius, & Bontempo, 2007; Hawkins & Catalano, 1992). The goal of this study is to examine which aspects of coalition functioning best predict a coalition's ability to promote high-quality implementation of evidence-based programs (EBPs) over time.

Method: Aspects of coalition functioning were measured annually from 2003 to 2007 in 62 Communities that Care (CTC) coalitions in Pennsylvania using the reports of both coalition members and technical assistance providers. Coalition ability to support EBP implementation was measured in 2007 by asking coalition leaders to report the number of EBPs their coalition was supporting, the intensity of support provided by the coalition, and the degree to which best practices were utilized to promote EBP implementation fidelity.

Results: Findings indicate that the extent of community poverty and age of the coalition predicted decreased coalition support for high-quality EBP implementation. Including these two variables as controls in longitudinal analyses, we found that several indicators of high-quality coalition functioning (e.g., board directedness, staff-board communication, task-focus, fidelity to the CTC model, board cohesion, leadership, and positive community relations) significantly predicted a coalition's ability to support high-quality EBP implementation. Surprisingly, earlier measurements of coalition functioning (2003-2004) predicted EBP implementation (2007) more strongly than later measurement of coalition functioning (2005-2006).

Conclusions: Results suggest that coalitions in low income communities, and more mature coalitions, may have the most difficulty supporting EBPs. Higher quality coalition functioning appears to influence later program fidelity practices. However, results indicate that changes in coalition functioning alone may take some time to impact EBP implementation quality. Implications for how both coalitions and technical assistance providers can take action to improve EBP implementation will be discussed.

Acknowledgements: This research has been supported by a series of grants from the Pennsylvania Commission for Crime and Delinquency (PCCD). However, findings and recommendations herein are those of the authors and not official statements of PCCD. We acknowledge the enthusiastic support of Clay R. Yeager, Ruth Williams, Charles Gray, Doug Hoffman, Ray Moneta, Mary Ann Rhodes, Beverly D. MacKereth, and Henry Sontheimer at PCCD in supporting the vision of this project.

7. A RESEARCH-PRACTICE-POLICY PARTNERSHIP FOR PROGRAM DISSEMINATION

Presenter: Brian K. Bumbarger

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Abstract

Introduction: Since 1998, the Pennsylvania Commission on Crime and Delinquency (PCCD) has funded nearly 200 replications of evidence-based prevention and intervention programs throughout the state. Beginning in 2001, PCCD formed a partnership with the Prevention Research Center (PRC) at Penn State University to provide technical assistance to support the large-scale dissemination of evidence-based prevention and intervention programs, and to conduct research on the variables associated with the adoption, quality implementation, and sustainability of these programs. The strength and value of the partnership are characterized by the utilization of research findings both for continuous quality improvement of the initiative and to strategically impact state policy and resource allocation.

Methods: In addition to qualitative interviews and site visits, the primary method of data collection has been an annual web-based survey of approximately 200 program implementers. The survey assesses constructs related to the decision to adopt programs, the connection of the implementing organization to a local prevention coalition, strengths and barriers associated with implementation quality and fidelity, the frequency, cause and nature of adaptations, and the extent and source of sustainability. Three annual waves of data will be presented.

Findings: Measuring across time, we found several characteristics associated with communities' motivation to adopt evidence-based programs, as well as a number of factors correlated with implementation quality and fidelity, reasons for adaptation, and sustainability. The presentation will discuss how these findings were used to improve the initiative, including the funding process and the type and amount of technical assistance provided to communities. We will also discuss how data has been presented to legislators and policy makers to impact their support for dissemination efforts.

Acknowledgements: This research has been supported by grants from the Pennsylvania Commission for Crime and Delinquency (PCCD). However, findings and recommendations herein are those of the authors and not official statements of PCCD.

8. INSIDE THE BLACK BOX OF AN EBP: CTI FROM AN IMPLEMENTATION PERSPECTIVE

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Abstract

Critical Time Intervention (CTI) is a psychosocial intervention designed to prevent recurrent homelessness among people with severe mental illness by enhancing continuity of care during the transition from institutional to community living. CTI has been endorsed by SAMHSA's National Registry of Evidence-Based Programs and Practices and dissemination is underway. While CTI's structure has been well articulated, questions remain regarding how the model is adopted and implemented in various community settings. This study aimed to explore first-hand experiences of CTI workers trained by the model developers. Results are intended to bolster model fidelity and inform program dissemination.

Twelve CTI workers from five service settings participated in one-on-one interviews with the principal investigator. We employed the grounded theory methodology. Embedded in Symbolic Interactionism, grounded theory explicates social interactions and contextual influences and therefore is particularly suitable for studying the adaptation of evidence-based interventions and practice patterns within specific settings.

From line-by-line comparative analyses of verbatim transcripts, the study found that CTI practices were subject to (a) client conditions, (b) the model design, (c) service settings, and (d) systemic constraints. That is, on one hand, CTI workers attended to fundamental CTI features (e.g., specific phases and timeframe) and tailored the pace and strategies to individual client needs. On the other hand, workers delivered CTI in a way that incorporated current organizational arrangements and resources and adjusted to system limitations (e.g., housing availability). The latter particularly demonstrates the nature of CTI as a transitional model, i.e., both ends of the transition – the host setting of CTI and the housing placement for the client – shaped the practices and strategies used to achieve program effects. Findings identify special assessment and skill sets in CTI practices and pinpoint organizational influences important for program adaptation.

Funding was awarded by the Columbia Center for Homelessness Prevention Studies (P30 MH071430).

9. COMMUNITY-GENERATED RECOMMENDATIONS FOR DISSEMINATING RESEARCH

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Abstract

In order to ensure translation of research to practice, research should be disseminated in an appropriate and timely manner to the appropriate consumer, public health or clinical practice audience. Yet many researchers are not trained, rewarded or supported to disseminate research findings beyond academic journals.

The Community Advisory Board (CAB) of the Center for AIDS Prevention Studies (CAPS), University of California San Francisco, has encouraged and guided researchers in expanding their dissemination efforts to better reach providers, policymakers and community stakeholders. The CAB developed "Recommendations for Research Dissemination," which are unique because community stakeholders, many of whom have struggled with accessing research in a timely way, generated them. (caps.ucsf.edu/projects/collaboration/dissemination.php)

The CAB began by quantifying their own experiences both receiving (or not) and disseminating research findings. They conducted informal key informant interviews and focus groups with researchers at CAPS as well as outside of UCSF. They also conducted archival research to see if there were other institutions that had guidelines for research dissemination.

The CAB identified several barriers to successful nontraditional dissemination: lack of time and money; lack of knowledge regarding how providers access and use research; little consideration of nontraditional dissemination during faculty promotions; and government funder and scientific journal restrictions on disseminating through nontraditional means. While acknowledging these concerns, the CAB agreed that researchers should adhere to some minimum requirements for dissemination.

The Recommendations highlight several important considerations for researchers regarding plans, budgets and what types of data to disseminate, and offer highly pragmatic and feasible ways to accomplish this. In addition, the Recommendations emphasize the role of academic institutions in ensuring timely dissemination of research results to consumers, public health and clinical practice audiences.

10. PURLS: A NOVEL SYSTEM FOR DISSEMINATING EVIDENCE INTO PRACTICE

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Abstract

Background: Thousands of research studies are published annually. Evidence that changes clinical practice immediately is difficult to identify, and usually not disseminated or implemented in a timely manner.

Objective: To develop and plan web enabled and electronic health record based systems to systematically identify, disseminate, and implement only the new research evidence that should change primary care practice immediately.

Methods: We developed and implemented a system that rapidly identifies and disseminates new research evidence that should immediately change family medicine and primary care practice. The Priority Updates from the Research Literature (PURLs) surveillance system includes five components: surveillance, critical appraisal, empirical analysis of current practice, evaluation of feasibility in practice, and publishing a concise summary that includes a brief literature review and current clinical context (a PURL) for dissemination. Original research studies must meet the following criteria for dissemination as a PURL; 1) clinically relevant 2) scientifically valid (evidence based) 3) leading to a change in current practice, and, 4) readily implemented by US primary care clinicians. Currently, PURLs are disseminated through publication in print and online to 65,000 primary care clinicians, including web based polling. Plans for additional dissemination and implementation using interactive web based tools and decision support tools via electronic health records will be described on the poster.

Results: All original research studies published from July 1, 2008 to June 30, 2009 from 170 medical journals were considered as potential PURL candidates. Fifteen studies, including 12 randomized controlled trials and 3 meta-analyses, from 13 different journals, met the criteria and were disseminated as PURLs.

Conclusion: We have successfully developed and implemented the first system that identifies and disseminates only highly selected research evidence ready for immediate implementation in US primary care practice. As we anticipated, very few studies fulfilled our criteria, which makes dissemination and implementation more feasible.

Funding: The PURLs Surveillance System is supported in part by Grant Number UL1RR024999 from the National Center For Research Resources, a Clinical Translational Science Award to the University of Chicago and a contract with Dowden Health Media to the Family Physicians Inquiries Network. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Center For Research Resources or the National Institutes of Health or Dowden Health Media.

11. SUSTAINABILITY OF COMMUNITY PREVENTION COALITIONS

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Abstract

Objective: The community coalition approach has recently been shown to produce public health impact if best practices are utilized, after many years in which evaluations had generally not found the coalition approach to be effective. The next challenge is to foster sustainability among coalitions in order to achieve long-term public health outcomes. Accordingly, this study examined the level of and predictors of sustainability among Communities That Care (CTC) sites in Pennsylvania.

Methods: We assessed CTC board functioning and funding of 110 CTC sites through the reports of board members, staff, and TA providers from 2003 through 2006.

Results: 90% of CTC coalitions continued after the three-year initial funding period. Survival analysis shows 3-8% of sites terminating each year thereafter. About two-thirds of CTC sites continued to operate four years after the termination of the original three-year implementation grant. Many of the sites attracted funding at a level equivalent to or greater than that initial grant. Overall coalition functioning, reported on by either board members or TA providers, as well as planning for sustainability, predicted both survival and post-launch funding.

Conclusions: Evidence suggests that board functioning predicts survival, at least in part independently of its influence on funding; and planning for sustainability predicts sustainability, at least in part independently of overall coalition functioning.

Acknowledgements: This research has been supported by a series of grants from the Pennsylvania Commission for Crime and Delinquency (PCCD). However, findings and recommendations herein are those of the authors and not official statements of PCCD. We acknowledge the enthusiastic support of Clay R. Yeager, Ruth Williams, Charles Gray, Doug Hoffman, Ray Moneta, Mary Ann Rhodes, Beverly D. MacKereth, and Henry Sontheimer at PCCD in supporting the vision of this project.

12. CHICAGO MODEL FOR PROMOTING CHANGE IN HEALTH CARE POLICY AND DELIVERY

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Abstract

Introduction: In Chicago the mortality rate from breast cancer for African Americans (AA) is twice that of Caucasians, even though the incidence is lower. The objective was to test a model for systematic dissemination of research findings to the public, to promote change in health care policy and the delivery system to address this disparity. A key component of this model was the development of strategic partnerships among researchers, clinicians, and community leaders to mobilize public support.

Methods: The effort was launched by releasing a report showing the growing disparity in mortality, followed by a public summit. Three work groups were organized to address the hypotheses that AA women in Chicago receive fewer mammograms, mammograms of inferior quality, and inadequate quality of breast cancer treatment. Seventy-four Chicago area organizations participated in the three work groups from January to September, 2007. The work groups held focus groups, organized town hall meetings, and collected data on mammography capacity and quality. The Taskforce Report presented data supporting the three hypotheses and provided 37 evidence-based recommendations. Released at a press conference in October (300+ attendees), the Taskforce Report received wide media coverage, including television and *Newsweek*.

Results: Spurred by the work of the Taskforce, Illinois has become the first state to pay for mammograms for all uninsured women, as well as assist with breast cancer treatment. Legislation to address additional recommendations passed unanimously in the Illinois House of Representatives and Senate. Funding from the Avon and Komen Foundations has been earmarked to address the recommendations. A consortium of health care organizations has been convened by the Taskforce to improve quality. A taskforce in Houston is currently in development following the Chicago model.

Conclusion: The Chicago model provides effective city-wide strategies for promoting change in health care policy and delivery.

Funding provided by the Avon Foundation and National Cancer Institute (NIH) grant P50 CA106743.

13. USE OF SIMPLIFIED FOREST PLOTS TO DISSEMINATE RESEARCH RESULTS

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Abstract

Objective: For clinicians to make decisions enlightened by current research, efficient methods for drawing their attention to results of meta-analyses may be useful. The purpose of this study was to explore the feasibility of disseminating meta-analytic results to hospital-based healthcare professionals.

Methods: Abstracts and accompanying forest plots originally published in the Cochrane Database of Systematic Reviews (CDSR) were simplified to eliminate clinicians' need for extensive statistical background. The simplified versions of both text and graphics incorporated: (a) full references for included studies, (b) populations represented, (c) sample sizes, and (d) magnitude and significance of both treatment efficacy and incidence of commonly studied complications. Installments of CDSR results were delivered weekly over 4 weeks using different presentation modes (simplified forest plots, simple text summaries, or both) and different delivery modes (email, employee mailbox, or both). Units from 7 hospitals participated. Each presentation-by-delivery approach was randomly assigned to hospital units. Evidence of clinicians' use of disseminated information to inform practice was measured at week 6 by questionnaire.

Summary of Results: 50 of 178 participants (28%) returned questionnaires. 68% (n=34) reported they had considered implications of the information for patient care. Delivery mode was not related to factual knowledge or consideration of research results. A partial breakdown in procedures for linking completed questionnaires with hospital units limited ability to compare modes of presentation; however, subjects known to have received information in graphics format alone or graphics accompanied by text, reported significantly greater tendency to discuss information with colleagues than those receiving text only, $p<.05$. We conclude that widespread distribution of summarized research results using existing hospital communication channels is feasible. Additional studies are needed to explore if forest plots are effective formats for capturing attention of busy clinicians, stimulating consideration of research results, and creating a hospital work culture characterized by evidence-informed decisions.

Acknowledgements: Funded by the Detroit Medical Center Faculty Scholars Program

14. THE REINFORCING THERAPIST PERFORMANCE (RTP) EXPERIMENT: AN OVERVIEW

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Abstract

This poster provides an overview and description of the Reinforcing Therapist Performance (RTP) experiment — a study funded by National Institute of Alcohol Abuse and Alcoholism (NIAAA; R01 AA017625) that builds on a more than $30 million dissemination and implementation initiative funded by the Center for Substance Abuse Treatment (CSAT; TI 06007). As part of CSAT's Assertive Adolescent and Family Treatment (AAFT) initiative, approximately 100 therapists from 32 treatment agencies across the U.S. are receiving the same training and additional technical assistance to implement an evidence-based practice called the Adolescent Community Reinforcement Approach (A-CRA). For the RTP experiment, treatment agencies are randomly assigned to either a control condition or an experimental reinforcement condition. Therapists in the reinforcement condition receive monetary incentives for (a) each of their adolescent clients who receive an empirically derived target level of A-CRA, and (b) each month that a randomly selected therapeutic session recording is rated by an expert rater at or above the competence level required for A-CRA certification. The RTP study is still in its early stages; thus, the current poster will focus primarily on describing the rationale for the study, the procedures used to select the study's implementation targets, and pre-RTP data on implementation of the AAFT initiative. Upon study completion, however, planned analyses will evaluate the relative effectiveness and cost-effectiveness of the incentives to (a) increase the probability that adolescents receive at least the effective threshold exposure to A-CRA; (b) increase the probability of months in which therapist demonstrate A-CRA competence; and (c) increase the probability of adolescents having positive post-treatment outcomes.

15. DISSEMINATION AND IMPLEMENTATION (D&I) RESEARCH TO REDUCE TRAUMA

Presenter: Andrea Gielen, ScD, ScM

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Abstract

Trauma—unintentional and violent injury—is the leading cause of death in the United States from ages 1-44, and it costs society more than $400 billion annually. This public health problem is ripe for dissemination and implementation (D&I) research because there are many effective prevention interventions.

Objectives:

1) Describe the burden of injury in the US;
2) Provide evidence to support the readiness of the field for D&I research;
3) Demonstrate the application and utility of qualitative research methods to D&I research in injury prevention;
4) Illustrate how D&I research has been used to reduce injury risk in a low income, urban population at high risk for injury; and
5) Generate new ideas for D&I research to close that gap between research and practice to reduce the burden of trauma in the US.

16. A TRAINING MODEL TO PROMOTE HEPATITIS PREVENTION IN ADDICTION CLINICS

Presenter: Hildi J. Hagedorn, PhD

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Abstract

Objective: Based on the successful establishment of a hepatitis screening, education, prevention, and referral program at the Minneapolis VA Medical Center addiction clinic, a training program was developed to support implementation of the program in other VA addiction clinics. The program utilized an evidence-based training model developed by the Hepatitis C Resource Center which had previously been shown to improve processes of care for patients with chronic hepatitis C. This evaluation assesses the effectiveness of this training at promoting implementation of services to address hepatitis infections in addiction clinics compared to receiving educational materials only.

Methods: The training program includes a pre-training needs assessment, a 1.5 day in-person training, and 6 months of post-training coaching calls. Eleven teams from VA medical centers across the United States participated in the program. An additional five teams were mailed training materials and served as comparison teams. All 16 teams completed baseline, 1-, 3-, and 6-month follow-up assessments regarding current hepatitis services offered in the clinic and changes implemented in clinic practices.

Findings: Nine out of 11 clinic teams participating in the training reported two or more major practice changes by the six-month follow-up. Changes included routine testing for hepatitis infections; improved processes for providing feedback of test results and referral for medical evaluation to hepatitis C positive patients; offering hepatitis A and B vaccinations in the clinic; and establishing patient education classes on hepatitis infections. Two comparison teams reported one practice change and three reported no changes.

Conclusions: Results indicate that this multimodal training program is effective at promoting implementation of hepatitis services in addiction clinics and that the training program is more effective than mailed materials. This training model has the potential to serve as an effective method for implementation of a variety of improvements in health care processes.

Funding for this work was provided by the Veterans Health Administration's Quality Enhancement Research Initiative and the Hepatitis C Resource Center program.

17. **POSTER PRESENTATION**

Presenter: Diane Hanks

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Abstract

Primary Research Question or Hypothesis: Major depression is currently the leading cause of disability in the United States, and by 2020 it is projected to be the leading cause of disability worldwide. Most patients with depression are detected in primary care settings, with studies showing that about 20% of primary care patients screen positive for depressive symptoms. About half of these patients are being treated for mental health issues within the Department of Veterans Affairs (VA) healthcare system.

Multiple studies have demonstrated the effectiveness of collaborative care in improving treatment and outcomes for primary care patients with depression. The Translating Initiatives for Depression into Effective Solutions (TIDES) Project is an evidence-based collaborative approach to depression management that has proven successful within VA. One part of the dissemination plan to help enhance the spread of TIDES involved the development and distribution of "Collaborative Care for Depression in the Primary Care Setting: A Primer on VA's Translating Initiatives for Depression into Effective Solutions Project." The *Primer* was developed to provide information about collaborative care for depression, particularly in the primary care setting, and highlights TIDES. The *Primer* targets a broad audience of VA hospital and clinic managers, mental health clinicians, nurses, and others. It is written in a question and answer format and provides appendices that include a glossary of terms and list of resources for further information about depression and treatment.

Research Methods Employed in the Research: As a large part of the *Primer* is devoted to TIDES's impact on collaborative care for depression, specific research methods are relevant only to the TIDES project, not the *Primer*. The *Primer* is distributed to a wide audience within VA, and also is provided as a PDF on the HSR&D website (www.hsrd.research.va.gov).

Summary of Findings Supported by Presented Data: The *Primer* was recently disseminated, and we have received requests for more than 150 copies. We expect to have evaluation data on the usefulness of the Primer before the NIH conference.

With regard to the summation of findings, the Primer offers evidence of the success of collaborative care for depression in the primary care setting, particularly through TIDES. The TIDES project has shown that collaboration between primary care and mental health (including screening and assessment to identify the condition, symptom monitoring to guide treatment, and brief care management) are essential to effective treatment and improved outcomes.

Primary Source of Funding: Funding for the *Primer: Collaborative Care for Depression in the Primary Care Setting: A Primer on VA's Translating Initiatives for Depression into Effective Solutions (TIDES) Project* was provided by the VA Office of Research and Development, Health Services Research & Development Service.

18. CANCER CONTROL PLANNERS' USE OF EVIDENCE-BASED APPROACHES

Presenter: Peggy A. Hannon, PhD, MPH

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Abstract

We conducted a survey with cancer control planners from our community-based partner organizations to assess planners' needs in finding, choosing, and adapting evidence-based interventions. Each CPCRN Center surveyed $\geq$ 30 representatives from partner organizations: Almost 2/3 of respondents worked at the community level, and 1/4 at the state level; less than 1/3 were program planners or managers, 1/6 health educators, and 1/10 community outreach coordinators. Most participants (85%) had implemented cancer control programs within the past year. Virtually all respondents (93%) chose the correct definition of "evidence-based," and they placed high value on this characteristic. Among those who had used or adapted a program from someone else, the most frequently selected reason was "scientific evidence saying the program works." Few respondents indicated awareness of available evidence-based resources: Only 49% had heard of P.L.A.N.E.T., 43% had heard of the Community Guide, and 22%, R-TIPs. Use was even lower: 36% had used P.L.A.N.E.T., 28% had used the Community Guide, and 13% had used R-TIPs. Respondents who had used these websites found them useful (80-85% rated sites as "somewhat" or "very" useful). Users were also significantly more likely than non-users to endorse positive statements about the ease of finding and obtaining evidence-based programs. The majority of respondents indicated that training would help their organization adapt and implement EBAs. The most frequently selected training topic was finding and securing additional resources, followed by items related to assessing, adapting, and implementing and evaluating EBAs. Desire for training in these areas was not associated with prior use of the Guide, P.L.A.N.E.T., or R-TIPs. Findings from this survey were used to inform the conceptual model for an interactive Web-based tool under development to guide cancer control planners through the processes of identifying, choosing, adapting, implementing, and evaluating EBAs in communities.

Funding source: The work presented in this abstract was supported by the Centers for Disease Control and Prevention and the National Cancer Institute through the Cancer Prevention and Control Research Network, a network within the CDC's Prevention Research Centers Program.

19. EXPLORING THE AGING NETWORK'S CAPACITY TO IMPLEMENT DEPRESSION CARE

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Abstract

Objective: Although several interventions can effectively treat depression, older adults commonly receive inadequate treatment. Aging network services, such as senior centers, homecare services, adult day services, and supportive housing, may be able to improve access to quality depression care. Thus, this study describes their organizational context and current depression practices to identify their capacity to implement depression care.

Methods: Agencies that have ongoing contact with community-based older adults were stratified by type (i.e., senior centers, homecare services, adult day services, supportive housing). Using mixed methods, data was gathered on the organizational culture, climate, and structure, current depression practices, and provider attitudes through interviews with program managers (n=16) and surveys with staff (n=145). Multilevel modeling and constant comparative analysis informed interpretation of implementation capacity.

Findings: Agencies were primarily private and not-for-profit. One-third of staff had a college degree and most nurses/social workers were administrators. Adult day services typically had 20 clients or less; whereas, the other agencies reported serving over 100 clients. About half of the agencies (n=8) used systematic screening and offered psychoeducation; yet few (n=3) currently had suicide risk protocols or received mental health consultation. Although, these agencies traditionally offered care management; themes of limited funding, training, and time have reduced the number of care management clients. Implementation barriers were cited as: stigma, inconsistent acceptability by staff and agency leaders, questions of cost, lack of existing geriatric mental health resources to support change efforts, and policies that limit the scope of assessing mental health needs, such as Health Insurance Protection and Portability Act and the Fair Housing Act. Setting needs vary, with supportive housing and adult day service wanting increased consultation, senior centers requesting help with education, behavior activation, and screening, and homecare agencies specifying a need for easier reimbursement procedures for psychosocial assessments and psychotherapy.

Funding: Gerontological Society of America's John A Hartford Doctoral Fellowship (May 2007 to April 2009)

20. INCREASING RESEARCH CAPACITY: THE POWER OF COLLABORATIVE PARTNERSHIPS

Presenter: Laura L. Hayman, PhD, RN, FAAN

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Abstract

Purpose: Central to increasing research capacity for dissemination and implementation science is the development of innovative, sustainable interdisciplinary education and training programs. Toward that goal, the University of Massachusetts Boston (UMB)/Dana–Farber/Harvard Cancer Center (DF/HCC) established an academic-service partnership to develop a model program and prepare nurse scientists from diverse racial and ethnic backgrounds to generate, implement, and disseminate evidence necessary to reduce cancer health disparities and guide and inform multi-level health policies. Viewed within a social-ecological framework and guided by UMB's conceptual model for nursing and health policy, core components include didactic/substantive content and clinical and community-based experiences focused on prevention and management of cancer across the life course, health policy, health disparities, and research methods. Facilitated by the collaborative UMB-DF/HCC partnership, the centerpiece interdisciplinary mentorship component matches scientists and students and optimizes role socialization and acquisition and implementation of research- related competencies.

Methods: Program evaluation methods (ongoing) assess process and outcome measures. Qualitative methods including interviews conducted by an external evaluator capture the experience of mentors and mentees. Joint initiatives and outcomes including research and clinical/community based activities and presentations and publications in interdisciplinary forums are tracked.

Summary and Conclusions: Results to date indicate successful implementation of a collaborative UMB-DF/HCC academic-service partnership and the interdisciplinary education, training and research mentorship component. Expert external advisory review approved and commended the innovative curricular and mentorship components. Outcomes of the partnership and nine mentor-mentee dyads include joint publications in interdisciplinary peer-reviewed journals (n=18), invited collaborative presentations (n= 16), and research dissemination and implementation initiatives (n=5). Mechanisms for joint faculty appointments at UMB and DF/HCC have been implemented and plans for sustainability are underway. Taken together, collaborative academic–service partnerships, curricular innovations and interdisciplinary mentoring combine to increase research capacity and bridge the gap from science to service.

This project was supported in part by NIH/NCI Grant 1 U56 CA11863502 and by grants from the Lynch Foundation and GAANN, US Department of Education, P200A060243.

21. IMPLEMENTING COMPLEX SERVICE INNOVATIONS IN HEALTH CARE

Presenter: Jane Hendy, PhD

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Abstract

Health services literature provides limited guidance to managers on how to effectively implement complex innovations like electronic patient records, disease management and quality improvement initiatives. Focusing on the processes of implementation, we have developed an integrated conceptual model that determines innovation outcomes and sustainability.

The model has been developed by Hendy and colleagues researching the implementation of complex innovations in health care in the UK NHS. Innovations studied include information technology implementation in acute trusts, national service framework implementation in primary care, and remote care services implementation across the whole care system.

The model offers three advantages over other conceptual approaches. Firstly, it recognises that implementation is fundamentally a collective endeavor. Secondly, it recognizes the role of formal organisational structures and strategies in facilitating and inhibiting innovation use. Lastly, it accounts for the impact of implementation processes on innovation use and sustainability. For practitioners the model's constructs are general enough to be applied to a range of innovations and organisational settings, yet specific enough to permit operational definition and testing.

To ensure the model is useful for managerial practice, we are hoping to further test and refine the model, using two major NHS innovation initiatives (the £50m UK Whole System Demonstrator Programme and the £10m UK Collaboration and Leadership in Applied Heath Research and Care). Given the substantial investment of time, energy, and resources involved in the implementation of complex innovations in health sector organisations, the development of a stronger knowledge base to guide implementation efforts will make a significant difference to health care delivery and patient health.

22. SHIFTING CULTURALLY RELEVANT MENTAL HEALTH RESEARCH INTO PRACTICE

Presenters: Tracy Whitaker, National Association of Social Workers
Nancy Bateman, National Association of Social Workers
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Abstract

How do you shift culturally relevant mental health research from the national organization level into practice with diverse populations at the local level?

The National Association of Social Workers (NASW) and the Institute for the Advancement of Social Work Research (IASWR) set forth to develop and pilot test dissemination and implementation (D&I) action steps to ensure that culturally relevant, research-tested EBPs can be moved into social work practice in targeted service delivery settings. This was done by creating a web-based toolkit that incorporates information and resources on both evidence-based interventions to promote adolescent behavioral health, especially targeting adolescent girls who are at high risk for suicide, and evidence-based dissemination and organizational change strategies that have been found to be effective in moving research to practice. This tool-kit was then pilot-tested and refined through the training of state-based research to practice teams convened by NASW chapters in Georgia and Nevada.

The poster will provide an overview of the strategies that were used in this research to practice initiative as well as identify the challenges that were faced both in the development of the toolkit and the real world implementation of it. Strategies included accessing and assessing information from evidence-based practice clearinghouses (e.g., NREPP and SPRC), identifying and adapting culturally relevant evidence-based programs, and the creation of a dissemination and implementation framework that was tested by state research to practice teams. Discussion will be on strategies used by participants in overcoming the challenges faced, feedback on the dissemination and implementation framework that was developed, and suggestions for next steps.

Findings from this discussion will be compiled into a report and made available on the IASWR Web site (www.iaswresearch.org).

23. ADAPTING DESIGNS IN RESPONSE TO NATURAL IMPLEMENTATION TIMELINES

Presenter: Michael S. Hurlburt, PhD

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Abstract

Implementation of innovative services in community-based mental health service settings ranges from highly planned efforts that involve tight partnership and ongoing collaboration with researchers having tightly controlled timelines, to the more varied intensity and focus of efforts largely driven by service organization timelines and priorities. Unique questions and dilemmas arise for research that focuses on implementation occurring in a broader, less controlled cross-section of agencies seeking to adopt and implement innovative practices.

This presentation will consider a case study of a trial examining implementation of The Incredible Years basic parent training program. The study design has focused on understanding the impact of enhanced technical support and clinical supervision on efforts to implement the IY program, fidelity of program delivery, and ultimately parenting practices and child behavior. Implementation is occurring in diverse community-based mental health service settings. During the study to date, the varied implementation timelines of agencies in the study have raised a number of important issues, such as effective use of randomization at the case level in group-format interventions, finding a balance between encouraging organizations to implement and studying implementation timelines, controlling study recruitment flow, planning resource allocation effectively in response to changing implementation plans, and documentation of implementation process.

This case study will be presented from the perspective of how real-world agency implementation timelines can affect research design and from the perspective of approaches to managing resources in the context of implementation uncertainty among agencies participating in a trial.

24. QFD: A TOOL TO ADAPT A PROGRAM FOR DIVORCING FAMILIES FOR DISSEMINATION

Presenter: Sarah Jones, PhD

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Abstract

Prevention efforts have focused on developing and evaluating intervention programs to prevent a wide range of health, mental health and social problems. The task before today's prevention researcher is to effectively disseminate these programs to be delivered across a wide range of community and cultural contexts. Multiple problems have been recognized in implementing research based programs in community settings where the conditions are markedly different from those under which the programs were evaluated. Systematic methodologies to understand the conditions in which programs are to be delivered in the natural environment and to adapt programs to these conditions are needed. This presentation will summarize the use of Quality Function Deployment (QFD) to adapt the New Beginnings Program (NBP) for delivery in a community setting.

Three primary stakeholders were identified as community delivery agents for NBP: Family Court systems, community mental health agencies, and the culturally-diverse range of divorcing families. Three studies were conducted to identify the stakeholders' needs which could impact successful program adoption and delivery. As an illustration of this process, the investigation of the needs of the community agencies, and the process by which these needs were incorporated into the redesign of NBP, will be described.

Community agencies needs were identified through a variety of QFD procedures including focus groups, interviews with agency administrators and clinical providers, and the use of affinity and hierarchical diagrams. These needs were then prioritized with the Analytical Hierarchical Process tool (Saaty, 1977). These needs, in conjunction with needs of the court system and divorcing families, informed and guided the initial redesign of the NBP. Session prototypes were created and piloted in community settings and feedback was incorporated into the design. The QFD methodology represents an innovative and effective approach to the redesign of research-based programs for dissemination in community settings.

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25. IMPLEMENTATION OF SMOKING CESSATION IN SUBSTANCE ABUSE TREATMENT

Presenter: Hannah K. Knudsen, PhD

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Abstract

Given that about 70% of clients in substance abuse treatment also smoke, the implementation of the Public Health Service's clinical practice guideline, *Treating Tobacco Use and Dependence*, by treatment organizations has public health significance. Few studies have considered the research question: To what extent has this guideline been implemented in these settings? Drawing on existing national samples of substance abuse treatment organizations, telephone interviews were conducted with 620 program administrators (response rate = 88.4%). Interviews measured adoption of four assessment practices, and programs were also coded as having adopted an assessment "bundle" if they had implemented all four practices. The availability of a formal smoking cessation program and pharmacotherapy was measured. Organizational characteristics, including ownership, profit status, location in a healthcare setting, access to physicians, program philosophy, and delivery of outpatient-only treatment services, were drawn from previous interviews. While the vast majority of programs ask about current smoking during assessments (86.6%), fewer programs advise clients to quit (45.9%), assess willingness (46.7%), and use motivational interventions to increase willingness to quit (26.6%). Just 19.0% had adopted this bundle of four assessment procedures. Organizational characteristics associated with the adoption of this bundle included profit status, location in a hospital setting, 12-step treatment model, and offering outpatient-only services. The majority of programs (54.3%) neither offered a smoking cessation program or pharmacotherapy. About 13.4% offered both services, 5.8% offered a program without pharmacotherapy, and 26.6% offered only pharmacotherapy. Smoking cessation services were associated with location in a hospital, access to physicians, outpatient-only services, and adoption of the assessment bundle. These data indicate that implementation of the PHS guideline in substance abuse treatment organizations has been limited. Future health services research should aim to identify additional barriers to implementation within these healthcare settings.

Supported by the National Institute on Drug Abuse (R01DA020757, R01DA014482, and R01DA13110).

26. THE ROLE OF CHAMPIONS IN IMPLEMENTING INFECTION PREVENTION PRACTICES

Presenter: Sarah L. Krein, PhD, RN

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Abstract

Objectives: Champions are believed to play a key role in the implementation of new organizational practices. However, a number of factors influence the extent to which an identified champion might be an effective agent for promoting change. The purpose of this study was to examine the types and roles of champions in facilitating the implementation of key practices to prevent hospital-acquired infections in US hospitals.

Methods: We conducted a sequential mixed-methods study evaluating barriers and facilitators of infection prevention practices. First, we collected survey data about the use of different practices from over 500 hospitals across the US, then selected 14 hospitals for in-depth analysis using stratified purposeful sampling based on survey responses. We conducted semi-structured interviews with 86 individuals by phone and during visits to 6 hospitals. All interviews were transcribed, coded, and analyzed using rigorous qualitative analysis techniques.

Results: The types and numbers of champions varied with the type of practice implemented and how that practice interacted with structural features of the organization. For example, while a single well-placed champion may be able to promote adoption of a new technology, changes that require behavior modification often require more than one champion. While the behavior changes themselves may appear simple, implementation complexity increases significantly and often requires inter-professional coalitions working together. Rather than being appointed, true champions tended to be intrinsically motivated and passionate about the practices they promoted, although sometimes even these characteristics were not enough to overcome overwhelming organizational barriers.

Conclusions: Champions must navigate dynamic and complex interactions between the practices being implemented and organizational context. Practice characteristics, in addition to intrinsic attributes of champions and organizational context, influence the number and type of champions and their capacity to implement change.

This project was funded by the Department of Veterans Affairs, Health Services Research and Development Service (SAF 04-031) and the Ann Arbor VAMC/University of Michigan Patient Safety Enhancement Program.

27. ADOPTION OF EVIDENCE BASED PRACTICE IN MINORITY FOCUSED DRUG PROGRAMS

Presenter: Sandra Larios, PhD, MPH

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Abstract

There is now wide agreement that drug abuse treatment is effective in ameliorating the personal, family, social, and economic impacts of substance abuse. National leadership in this field has recognized the need both to establish effective treatments and to extend these treatments to those in need. Few studies, however, have explored predictors of treatment adoption in substance abuse settings. The current project explores issues related to improving the quality of addiction treatment for alcohol and other drugs in ethnic and sexual minority focused programs, and identify factors that may increase the adoption of evidence based practice (EBP) in minority populations. Specifically, the project uses qualitative interviews to help develop an instrument to measure community-based clinical trial characteristics as they relate to the dissemination of research findings into community settings. Interviews will be conducted with directors and two key program staff in ethnic and sexual minority focused drug programs, exploring research characteristics that influence the implementation of EBP in these programs. Using open-ended questions, we will collect information about: 1) the programs' experience participating in research and evaluation projects; 2) research characteristics that support implementation of EBP in minority-focused drug abuse treatment settings; and 3) research characteristics that impede implementation of EBP in these settings. Participants will be asked about factors related to intervention, training, and research methods including sample, comparison strategy, assessment, and results, as well as partnership issues. For the analyses we will use the grounded theory approach developed by Glasser and Strauss (1967). This inductive approach is used to generate theory from data, rather than to test already existing hypotheses, and is consequently an appropriate method for exploratory research. Findings will be used to inform the development and implementation of future policies related to EBP and to facilitate adoption of EBP in minority focused substance abuse treatment programs.

28. IMPLEMENTING ORAL HEALTH PROMOTION STRATEGIES IN HEAD START PROGRAMS

Presenter: Diane Paulsell, MPA

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Abstract

This study examined the capacity of Head Start programs serving low-income children ages birth to 5 to integrate oral health promotion and prevention strategies into program operations. The research examined strategies used by 52 Head Start programs that received grants to develop oral health interventions, and then identified the most promising strategies. The research team conducted semi-structured telephone interviews with program directors and key staff from all 52 grantees and used a web-based MIS to collect program-reported data on service use and characteristics of families and children. These data were used to rank grantees on measures developed under the Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) analytic framework. The research team then conducted site visits to 12 high-ranking and 4 low-ranking grantees to conduct interviews with staff and community partners and focus groups with parents. These data were coded using Atlas.ti. The site visit and MIS data were analyzed to identify promising strategies in nine areas: (1) training all Head Start staff on oral health education and promotion strategies for children and parents; (2) hiring staff, such as dental hygienists, to support and deliver oral health services at Head Start centers; (3) recruiting dental providers to serve Head Start families; (4) implementing case management procedures to increase rates of prevention care and treatment; (5) providing preventive care, such as oral exams and fluoride varnishes, on site in Head Start classrooms; (6) providing support services to help families make and keep dental appointments; (7) educating parents about the importance of oral health; (8) educating children about how to care for their teeth and what to expect during dental services; and (9) integrating oral health activities and services into existing management systems.

This research was funded through a contract with the Office of Head Start, Administration for Children and Families, DHHS.

29. DISSEMINATION OF DIAGNOSTIC IMAGING GUIDELINES

Presenter: Martin H. Reed, MD FRCP(C)
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Abstract

The Issue: The use of Diagnostic Imaging (DI) is increasing rapidly, but there is growing concern that a significant percentage of DI is not appropriate for the management of patients.

The Response: A number of DI organizations, including the American College of Radiology, the Royal College of Radiology and the Canadian Association of Radiologists (CAR), have developed guidelines for DI. These are available in paper format, on CD and on the internet.

The Problem: It is known that these guidelines can reduce DI examinations without compromising patient safety. However, it is also known that, as for many other guidelines, even with their availability in multiple formats, their effect is often not sustained over time.

The Future: With the development of electronic health records (EHR) and electronic medical records (EMR) the possibility of incorporating guidelines into computerized order entry systems (CPOE) so that physicians can receive the guidelines on an ongoing basis as part of their workflow is becoming a reality. In this format the guidelines should also sustain their effect over time.

DI is very rapidly becoming digitized with the widespread adoption of radiology information systems (RIS) and picture archiving and communication systems (PACS). By linking RISs and CPOEs it will be possible to determine outcomes of DI ordering both for individual physicians and populations at large. This as well as the detailed information that is stored in CPOEs will allow targeted interventions such as education to improve physicians' ordering patterns for DI.

This poster will discuss and illustrate these concepts and report on the author's work with a CPOE incorporating the CAR DI guidelines.

Funding: Health Canada and Manitoba Health

30. USING MULTIMEDIA AND E-LEARNING TO DISSEMINATE EFFECTIVE PRACTICES

Presenter: Anna Runkle

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Abstract

Introduction: Rapid advances in web-based technology have enabled us to integrate audio, video, animation, games and interactivity into online training programs for health care professionals and their patients. Multimedia can be particularly effective for demonstrating new behaviors (such as how to discuss an issue with a patient in a sensitive manner) as well as new processes (such as how to wrap a sterile package). The use of multimedia and e-learning can also support dissemination and standardization of effective practices across multiple locations, departments and staff levels. Yet as many of us have learned, these technologies can also become an expensive waste of time and resources.

In what situations can the use of multimedia enhance engagement, learning and retention, and how can we ensure its effectiveness? When does it make sense to put training online, and when are traditional training methods most effective? How can organizations begin to incorporate these new technologies into existing training programs, and what steps are necessary to sustain these lessons over time?
This oral presentation will use brief case studies and anecdotes from the presenter's professional experience, as well as key findings from research in the science of learning, to suggest the most practical and effective applications of multimedia and e-learning technology.

Primary Hypothesis: Video and multimedia are an ideal means of *demonstrating behaviors* and processes to health care professionals, especially when the organization seeks to standardize these changes across multiple sites, departments and staff levels.

Research Methods:

- Anecdotal and case study evidence from the presenters professional experience, including 20 years in health care training, communications and operations research, and four years producing e-learning, video and multimedia for health care
- Key findings from the book *E-Learning and the Science of Instruction: Proven Guidelines for Consumers and Designers of Multimedia Learning* by Ruth Clark and Richard Mayer (Pfeifer, 2008). Among E-learning professionals, this is considered to be the definitive text on the subject.

Findings Supported by the Research:

- Online training can be effective when training is mandatory or when learners are personally motivated to take the training (otherwise they don't bother); when learning must be evaluated (evaluations can be posted and tracked online); and when learners have the time and computer access to complete the training (not always the case in community clinics and other resource-poor settings).
- Video showing learners how to say or do something can be far more effective than classroom training, especially when learned behavior is to be standardized across multiple sites (ensures that everyone sees the right thing, and the same thing)

- Classroom or group training is appropriate when teams must learn and discuss a lesson together (online learning isolates learners at a computer station and is not conducive to group learning). Video, however, can be presented as a DVD in a group setting and hosted online for individual viewing.
- When e-learning is used, the following guidelines should be considered:
    - Graphics and text together are more powerful than graphics or text by themselves.
    - Text should be placed near the graphic it describes, vs. under it or after it. This helps the brain to integrate it.
    - Graphics and audio narration are better than graphics and text, because they use both auditory and visual learning channels within the brain, thus expanding the learners capacity to process information
    - When using graphic and narration, keep printed text to a minimum; three informational inputs makes the cognitive load too big and interferes with integration
    - For the same reasons, avoid unnecessary or irrelevant text or graphics
    - Use virtual coaches or even a photo with a voice; we are wired to respond to this
    - Break content down into small topic chunks; it is easier to integrate and also easier for learners to customize their curriculum
    - Teach important concepts and facts *before* procedures and processes
    - When asking the user to try something, start with an example that requires a little interaction and work your way up to more interaction.
    - Insert questions next to steps that have been worked out for the user, to encourage "self-explanation. Then provide explanations.
    - Give explanatory feedback on correct and incorrect answers.
    - The more advanced the learner is, the more control you should give him or her over navigation.
    - Limit choices for navigation (skipping sections) when learners are novices and/or learning outcomes are important.
    - Always give learners options to progress at their own pace, to review prior topics, and to quit the program.

31. COMMUNITY BASED ORGANIZATIONS AS A VENUE FOR GUIDELINE DISSEMINATION

Presenter: Donna Shelley, MD, MPH

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Abstract

Objective: To estimate the effectiveness of a community based tailored free nicotine patch (NRT) program plus minimal counseling among Chinese immigrants living in New York City (NYC). We hypothesized that taking advantage of channels for distribution outside the typical health care setting would increase dissemination of evidence-based smoking cessation services among this hard to reach population without reducing the treatment effectiveness.

Methods: The research team incorporated key principles of community-based participatory research (CBPR) in the final design of the intervention protocol. Between July 2004 and May 2005 a six week course of the nicotine patch was provided to 375 individuals enrolled in the study. Kits contained a 2- week supply each of generic 21mg, 14 mg, and 7 mg patches, a Chinese language instruction sheet and self help smoking cessation guide. Participants completed an in person baseline survey and a 4-month follow-up telephone survey.

Findings: Over a period of 10 months the intervention reached an estimated 8% of Chinese smokers in Flushing, This compared favorably to the 5% reach the NYC Department of Health and Mental Hygiene (NYCDOHMH) achieved with their 2003 population-based free patch program. Using an intention to treat analysis the abstinence rates at 4 months were 26.7% (100/375). The results demonstrate that offering free nicotine medication through easy to access, culturally competent local community organizations encourages a non English speaking immigrant population of smokers to access this evidence-based treatment. The findings also suggest that CBOs have the capacity to provide evidence-based tobacco use treatment effectively and are therefore a critical resource for dissemination of treatment guidelines to hard to reach immigrant communities. Finally, this study demonstrated the importance of using a CBPR framework to ensure cultural relevance and reach of tailored community based interventions. With the continued collaboration between the two CBOs and the NYCDOHMH the program is proving sustainable.

Funding Source: Centers for Disease Control and Prevention K01 DP000087-03

32. IMPROVING GUIDELINE IMPLEMENTATION THROUGH ENHANCED REFERRAL SYSTEMS

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Abstract

Hypothesis: 1) To test the hypothesis that an "expanded vital sign" chart stamp that prompts providers to offer 4 A's (ask, advise, assess, assist) plus an office-based fax referral system that links smokers to proactive state funded telephone counseling service will be more effective in increasing the rate of cessation assistance than the "expanded vital sign" intervention alone, and 2) To analyze the process of implementing tobacco use treatment guideline in community health centers (CHCs) in New York City (NYC).

Research Methods: This study was conducted in four community health centers (CHCs) using a quasi experimental study design. Two comparison sites offered usual care ("expanded vital sign" chart stamp) and two intervention sites received the chart stamp plus an office-based link to the New York State quitline. Provider adherence to the 4 A's was assessed with 263 pre and 165 post cross sectional patient exit interviews at all four sites. Post intervention qualitative interviews were conducted with 8 physicians and three focus groups with 30 nurses and medical assistants in the intervention sites only.

Principal Findings: Overall adherence to the 4 A's increased significantly over time in the intervention sites with no change from baseline in the comparison sites ($p<.001$). Based on the regression analysis, intervention sites were 2.4 ($p<.008$) times more likely to provide referrals to the state Quitline over time than the comparison sites and 1.8 ($p< .001$) times more likely to offer medication counseling and/or a prescription. An office-based fax referral link to a state Quitline combined with a chart reminder system significantly improved cessation assistance compared to a chart reminder system alone. Findings from the qualitative interviews suggest additional measures needed to ensure sustainability.

Funding source: Agency for Healthcare Research & Quality R03 HS016000-01

33. MODELING PEER-DRIVEN DISSEMINATION IN ONLINE SOCIAL NETWORKS

Presenter: Vincent M. B. Silenzio, MD, MPH

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Abstract

Background: Lesbian, Gay, and Bisexual (LGB) adolescents and young adults are at increased risk for suicide ideation and attempts. These youth represent a "hidden population" not easily accessible due to their relative social and geographic isolation, as well as the social stigmas surrounding suicide and sexual orientation. However, these individuals report high rates of using emerging Internet technologies, particularly to facilitate peer-to-peer interactions. Thus, emerging technologies such as online social networks offer opportunities to overcome previous barriers in suicide prevention research or interventions targeting this population.

Methods: Using a breadth-first search algorithm, we mapped the LGB peer network of individuals between 16 and 24 years of age participating in a popular online social network. We then used Monte Carlo simulations to model the dissemination of a peer-driven preventive intervention under varying starting conditions.

Results: We mapped a network of 100,014 young LGB. The mean age was 20.4 years. The number of LGB peers ranged from 1 through 4,309, with an underlying exponential distribution and a mean of 137.5 LGB peers. The Monte Carlo simulations of peer-driven dissemination ultimately reached between 1,206 and 18,396 individuals. Peer-driven dissemination was more sensitive to increases in the maximum peer recruitment allowed per participant than to increases in the number of participants selected at the beginning of the intervention.

Conclusions: The underlying LGB peer network structure is consistent with having formed dynamically through a process of preferential attachment. This implies that "well-connected" individuals within the network can be targeted to maximize dissemination. However, identification of these individuals has been shown to be highly resource intensive. Our results suggest that varying the number of peers that can be recruited may be an effective alternative. These findings are directly informing development of iPod/iPhone and similar applications to expand our suicide prevention research capacity in LGB peer networks.

34. TRAINING SOUTH AFRICAN COUNSELORS IN CBT: A COMPARISON OF 3 MODELS

Presenter: Ruthlyn Sodano, PhD

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Abstract

Introduction: Stimulant dependence is of great concern in the Republic of South Africa, particularly due to its relationship with risky sexual behavior and concurrent increase in rates of HIV/AIDS in the region. Cognitive behavioral therapy (CBT) is an empirically supported treatment for stimulant dependence. However, little is known about the most effective and efficient way of training front-line counselors in this treatment approach. This study aims to evaluate three training models for instructing South African counselors in CBT skills for treatment of stimulant dependence.

Methods: To date, 119 counselors have been randomly assigned to one of three conditions: 1) an in-vivo training, 2) a distance learning training, and 3) a self-study, manual-only training. Data and therapy session tapes are collected at baseline, 4-, 8-, and 12-weeks post training as well as a 24-week post training follow up to evaluate counselor retention, knowledge, and skill.

Findings: Interim examination of the means suggest that counselors in the manual-only condition had a higher rate of dropout compared to both the in-vivo and distance-learning conditions. Furthermore, there is no difference in retention between the in-vivo and long-distance training models, indicating both were equally effective in keeping counselors engaged. Examination of pre- and post-study CBT knowledge scores indicates a 5-point improvement in the in-vivo condition and smaller improvements in the other conditions. Collectively, these findings suggest that South African therapists prefer a more in-depth training model for learning CBT skills but only the in-vivo training model appears to result in an increase of CBT knowledge 12 weeks after the training. Please note that we did not statistically analyze the data because the study is still in progress and therefore the dataset is incomplete. Final conclusions regarding retention and the extent and skill with which South African counselors implemented CBT await the conclusion of the study.

This research is supported by a grant from the National Institute on Drug Abuse (NIDA), USA R01 DA019063-01A1.

35. ADOPTION AND EVALUATION OF AN EVIDENCE-BASED INTERVENTION IN NAMBIA

Presenter: Bonita Stanton, MD

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Due to a 1993 HIV sero-prevalence of 5% among antenatal patients in Namibia, UNICEF formed a collaborative international workgroup that included the Namibian Ministries of Health, Youth and Sport, and Basic Education and the developers of Focus on Kids (FOK), a HIV prevention intervention identified by CDC's Prevention Research Synthesis Project as an evidence-based intervention (EBI). The workgroup conducted qualitative and quantitative research among 922 youth to adapt FOK for Namibian youth. Adaptation has been defined as the process of modifying an intervention without competing with or contradicting its core elements. The intervention was augmented (from 8 to 14 sessions), changed to be culturally meaningful, and named "My Future! My Choice!" (MFMC). A randomized, controlled trial conducted among 515 youth found that virgins who participated in the intervention compared to control virgins were significantly more likely to not initiate sex. Further, intervention youth who did initiate sex were significantly more likely to use a condom. Between 1996-2001 MFMC was delivered to over 140,000 youth. However, twice during this time substantial revisions were made to the intervention. MFMC was diffused to other countries including Mozambique where an estimated 12,000 youth were reached. Although natural diffusion of EBIs is exciting, questions remain about implementation fidelity. CDC proposes that reinvention occurs when changes are made that compete or conflict with the core elements of an intervention. When reinvention occurs it is not known whether the program outcomes will remain; therefore, CDC recommends rigorous evaluation and renaming altered interventions. However costly rigorous evaluation is not always possible in resources constrained areas. This presentation will explore the difficult questions of diffusion, adaptation, fidelity, and evaluation using McKleroy et. al.'s Map of Adaptation Process: A Systematic Approach for Adapting Evidence-Based Behavioral Interventions.

Problems being addressed: When does an evidence-based program stop being "evidence-based"?

Science To Service In Justice Settings: Aligning Public Safety And Health Goals—3 Posters

36. 1st Poster: ADOPTING AND IMPLEMENTING EVIDENCE-BASED PROCESSES IN JUSTICE SETTINGS: RESULTS FROM A NATIONAL SURVEY OF CRIMINAL JUSTICE TREATMENT PRACTICES

Presenter: Faye S. Taxman, PhD

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Abstract

A recent survey of criminal and juvenile justice agencies and associated drug treatment agencies (n=1040), drug treatment courts and providers (n=467), and service providers offering co-occurring disorder services (n=757) paints a portrait about the adoption and implementation of evidence-based practices. Survey findings reveal that the average correctional agency adopts about one-third of the recommended evidence-based practices to treat substance abuse disorders. Multivariate models were used to identify factors that predict adoption and implementation of evidence-based practices. Size of the correctional population served was not found to be important in advancing implementation efforts. An organizational learning climate, a performance driven culture, integrated service delivery models, and networking processes are statistically related to the adoption and implementation in various settings across seven different innovations (e.g. use of HIV testing, use of cognitive-behavioral therapies, use of standardized risk and need tools, etc.). These characteristics will be described and some of the strategies used in the field to develop organizational learning and performance driven culture in correctional settings to advance the use of evidence based practices. Survey findings can inform two conceptual models on issues related to adoption and implementation, and the important factors to engage the correctional agencies and external stakeholders. The poster discusses strategies to advance the adoption and implementation within justice settings based on survey findings of correctional agencies and treatment providers.

37. **2nd Poster: COLLABORATIVE BEHAVIORAL MANAGEMENT MAKES PAROLE MORE SUPPORTIVE**

Presenter: Peter D. Friedmann, MD, MPH

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Abstract

Research suggests that intensification of parole can yield more violations if parole's culture of surveillance is not rendered more supportive. Collaborative Behavioral Management (CBM) brings parole officers and treatment counselors together to support positive behavioral change among drug-involved offenders in the community. An adaptation of NIDA's role induction and community reinforcement approaches, the four components of CBM establish collaboration between the parole officer and treatment counselor; clear, concise, and feasible expectations for supervision and treatment; a weekly behavioral contract for target behaviors; and monitoring and reinforcement of target behaviors by earning points that lead to locally-acceptable rewards, as well as graduated sanctions. We hypothesized that despite intensifying parole, CBM would make parole more supportive and thus less likely to result in increased parole violations.

Step'n Out randomized 569 parolees and probationers in 6 sites among 5 states to either CBM or traditional supervision; 476 reached community supervision (233 to control, 243 to CBM); 92% completed follow-up at 3-months, 87% at 9-months. Over 3 months, CBM integrated parole and treatment, as evidenced by an increase parole and treatment on the same day (2.7 days for CBM vs. 1.6 for traditional parole); intensified supervision, increasing mean number of contacts (14 for CBM vs. 11 for traditional parole) and face-to-face contacts (10 vs. 8) ($P<.001$); improved parole officer-parolee relationship and therapeutic alliance score ($P<.001$); and decreased parole violations over 9 months, with a mean of 0.2 violations per 100 community days in the CBM group versus 1.85 in the traditional group ($P=.03$). We conclude that CBM effectively intensifies parole, integrates supervision with treatment, and though improved rapport and therapeutic alliance, does not increase parole violations.

38. **3rd Poster: DETENTION TO COMMUNITY (DTC): TESTING AND IMPLEMENTING A COMPREHENSIVE, MULTI-STAGE, FAMILY BASED INTERVENTION FOR DRUG USING JUVENILE OFFENDERS**

Presenter: Howard A. Liddle, EdD

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Abstract

In the last decade, significant progress is evident in the adolescent drug abuse specialty. Effective science based interventions, and new practice informing research on developmental psychopathology and co-morbidities of teen drug problems are among these advances. At the same time, little progress has been made in crafting effective, systems integrating drug abuse treatments for juvenile offenders. As part of the CJDATS1 collaborative, the Detention to Community study is a two site randomized controlled trial (n=154) that tested a new intervention. Building on previous successes of the multidimensional family therapy (MDFT) approach, the MDFT-DTC approach was designed to link the juvenile justice and drug abuse treatment systems. Participants were assigned to either the MDFT-DTC condition or an enhanced services as usual intervention. Both interventions began with the youth in detention and continued for four months after release, and both included a basic CDC standard group HIV prevention intervention. Longitudinal growth models were used to analyze the outcome data. Findings demonstrate the comparative superiority of the MDFT-DTC treatment on all major outcome indices of HIV - STD prevention, drug use, delinquency, mental health, as well as significantly different engagement and retention rates favoring the MDFT-DTC model. Although implementation of the experimental treatment was consistent at the two study sites, sustainability of the intervention was not due to differential juvenile justice cultures. The presentation concludes with a lessons learned discussion on the differential sustainability outcomes in this study and their implications for the transfer of the MDFT-DTC model.

39. USE OF A CQI PROCESS TO MONITOR AGENCY ADOPTION OF SUPPORTED EMPLOYMENT

Presenter: Miriam C. Tepper, MD; Dana Holley, LICSW

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Abstract

Introduction: This project assessed whether a computerized Continuous Quality Improvement (CQI) system could be used to monitor the implementation of supported employment, an evidence-based practice. Unlike post-facto 'report cards' on the effectiveness of program implementation, CQI is a process-oriented approach of giving feedback to agencies in advance of reports to primary stakeholders and funding agents. The CQI system under study builds on standardized daily service logs kept by many programs for reporting purposes, and could be easily adapted to fit the needs of any local healthcare agency and be used with any software package.

Methods: This project assessed the computer-based CQI process in place at a multi-service psychiatric rehabilitation agency serving adults with serious mental illness, and focused on employment. Staff at this agency use daily service logs to record how they spend their time, including date, time of day, duration, and location of each activity. If the activity is a direct service, staff also code the recipient, need addressed, and type of service provided, and write a brief description. Client mainstream employment is tracked separately by staff in a relational database. Quarterly CQI reports have been provided to staff for nearly four years.

Findings: Hierarchical regression analysis of CQI data demonstrates that supported employment was successfully integrated into the agency's existing services. Receipt of individualized employment services predicts new job starts when controlling for client characteristics and days of program attendance. Detailed analyses reveal that clients who started new jobs received these specialized services prior to the first day of work, and in a manner that fit well with the agency's philosophy of client empowerment.

40. ADOPTION OF BREAST CANCER TOUCHSCREEN KIOSKS: KEY CONTEXTUAL FACTORS

Presenter: Armando Valdez, PhD

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Abstract

Research Questions: An effective interactive, multimedia touchscreen kiosk has been developed to deliver an individualized, self-paced breast cancer screening promotion intervention to low-income, low literacy Latinas in community clinic settings. This innovation has the potential to sufficiently impact Latina screening and early detection rates if diffused nationally among community clinics that serve predominantly low-income Latinas. This study posits that implementation of innovative, technology-based, prevention interventions in community clinic settings is driven by contextual factors in the host institutions. The overarching research question framing this study is: what are the comparative influences of institutional factors and intervention attributes in an adoption decision for breast cancer education kiosks in community clinic settings? The specific research questions are (1) to what extent do contextual factors, existing clinical practices, and efficacy attributes of the intervention factor into the adoption decision? and (2) what perceptions of institutional fit among the key decision-makers at the host institutions shape their adoption decision?

Methods: This study employs a multidisciplinary approach that combines medical anthropology, organizational behavior, health promotion and cancer prevention to identify barriers and facilitators to adoption and implementation of innovative, technology-based breast cancer education kiosks in community clinics. This qualitative, ethnographic study examines adoption decision-making in the context of the institutional culture and structure of community clinics, their institutional practices related to cancer screening and prevention, their prior experiences with information technology in clinical practice, the degree of institutional change and resources encumbered by the preventive care.

Expected Outcomes: The proposed study will extend construct of readiness to adopt to institutions and identify contextual factors that shape an institution's readiness to adopt the intervention. These findings will advance our understanding of institutional fit and also inform a dissemination strategy to promote subsequent implementation of the innovations in clinical settings.

41. ADAPTATIONS AND REINVENTIONS OF HIV PREVENTION INTERVENTIONS

Presenter: Rosemary C. Veniegas, PhD

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Abstract

The U.S. Centers for Disease Control and Prevention recommends adapting evidence-based interventions' key characteristics, which are activities or delivery methods, to better suit implementers' or participants' needs. Core elements of these interventions, which are the components considered responsible for their effectiveness, are not to be modified or deleted. Changes to core elements are considered reinvention. A qualitative study was conducted to assess the types and timing of adaptations and reinventions that were made to evidence-based HIV prevention interventions.

Participants were community-based organization staff (N=34) who had implemented HIV prevention evidence-based interventions in Los Angeles, California. A semi-structured interview was administered to all participants. Interview segments (n=287) were independently coded by two coders in terms of three broad categories of activities: adapting interventions to new target populations, modifying key characteristics, and intervention reinvention. The timing of the adaptations was also coded as occurring during pre-implementation, implementation, or maintenance and evolution phases. The kappa for inter-rater reliability was 0.75.

Staff actively and continuously modified key characteristics and core elements of the evidence-based interventions being delivered. Modifications to key characteristics included adding activities to sessions, integrating the intervention with other client services/programs, using incentives to attract or to retain participants, and modifying the duration or location of intervention delivery. Core elements which were modified included allowing non-target group members to attend the intervention, increasing the number of and content of sessions, and adding components required by the intervention funder.

Community-based organization staff who are using evidence-based interventions can benefit from technical assistance on determining whether desired adaptations are consistent with core elements and behavioral theory. Focused technical assistance is needed for continuous monitoring and quality assurance of the consistent delivery of adaptations.

This study was funded by the California HIV/AIDS Research Program IDEA Award mechanism.

42. DILEMAS IN CROSS-CULTURAL BEHAVIORAL HEALTH PROGRAMMING

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Abstract

Description: It is important to consider the role of culture in both the behavioral health service system and the different peoples served by it. Culture not only shapes the ways in which people understand and respond to substance use and mental health issues, it also structures the kinds of services that are conceptualized and enacted in response to them. In order to affectively provide services to a given community, it is important to consider the ways that that cultural group typically understands and responds to a health or social concern while paying attention to the context of these beliefs and practices. This is particularly important when the service systems are developed within a different cultural referent than that of recipients. To best serve people who do not reflect the dominant society, an examination of the cultural congruence between the service structures and those of the recipient community should be done to discern the cultural "fit".

The case example describes the cross-cultural difficulties exemplified in the suicide prevention and intervention efforts taking place in an Inupiaq community that suffers disproportionately from suicide. The case underscores some of the discontinuities in meaning between the Western service systems and this Alaska Native community that limit the effectiveness of suicide prevention and intervention strategies. Specifically the case presentation outlines these issues as they manifest in the contrast between the service system's and an Inupiaq community's general approach to prevention programming and to the specific strategies used in suicide crises. The implications and embedded assumptions of these strategies will be examined in order to invite discussion about more culturally-appropriate ways to conceive of and do suicide prevention and intervention in this and possibly other Indigenous communities.

The discussion is intended to be relevant to the conceptualization and provision of other cross-cultural behavioral health services.

43. USE OF MULTIMEDIA TECHNOLOGIES TO DISSEMINATE HIV PREVENTION

Presenter: Susan S. Witte, PhD

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Abstract

For over a decade, prevention scientists have demonstrated efficacy in HIV risk reduction approaches, while the science of program dissemination lags. We must close the gap between research discovery and program adoption to reduce new HIV infections. There is a need for increased capacity, scale and speed for HIV prevention intervention dissemination, and interactive multimedia technologies have the potential for achieving these goals. This paper describes the promising utility of multimedia and Internet-based technologies for the dissemination of HIV/STI prevention intervention. Described is an ongoing, innovative randomized clinical trial (RCT) to test dissemination of a "best-evidence" HIV/STI prevention program, Connect, comparing traditional versus multimedia-based technology transfer strategies among 80 HIV service organizations in New York State. A traditional DEBI, recently packaged by the CDC, Connect has been translated, keeping core elements intact, into an entirely multimedia and internet-based version called "Multimedia Connect" that can be easily implemented by a facilitator. Technology transfer of Multimedia Connect is also trainer-led, but includes all online training components. The RCT described is the first study examining dissemination of a couple-based HIV prevention intervention. It is also testing a prototype model of multimedia and Internet-based tools for dissemination that, if successful, may be employed for use in the prevention or treatment of an array of other mental health, health and human services-related issues. The study integrates community-based participatory research (CBPR) to assure best practice in the research-to-practice translation and implementation process and cultural congruence. The study will also provide new data on levels of program fidelity for traditional versus multimedia dissemination approaches. If successful, the study will advance prevention science by leveraging the power of new media to test the effective translation and dissemination of an evidence-based prevention intervention in real world settings.

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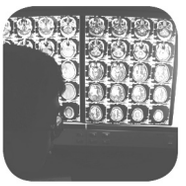




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